

**INFUSION & MEDICAL CENTER**

**1. Patient Name** \_\_\_\_\_ **DOB** \_\_\_\_\_ **Patient Phone/Cell #** \_\_\_\_\_

**Patient demographic and insurance information to be faxed with Infusion Order Form**

**2. Medical Information (Please select primary diagnosis and complete ICD10 Code):**

Primary Diagnosis: \_\_\_\_\_ Iron Deficiency Anemia ICD-10 Code: D50.9  
 \_\_\_\_\_ Iron Deficiency Anemia secondary to blood loss (chronic) ICD-10 Code: D50.0  
 \_\_\_\_\_ Anemia complicating pregnancy ICD-10 Code: O99.019  
 \_\_\_\_\_ Other: \_\_\_\_\_ ICD-10 Code: \_\_\_\_\_  
 Allergies: \_\_\_\_\_ (or attach list)

**3. Clinical Information – Please fax with Infusion Order Form:**

- Clinical notes, labs, test supporting primary diagnosis
  - Recent lab results including a hemoglobin, hematocrit and iron studies
- Infusion Center — Lab Orders: \_\_\_\_\_

**Patient**  
**Weight:** \_\_\_\_\_ lbs.  
**Height:** \_\_\_\_\_ in.

**MONOFERRIC® (ferric derisomaltose)**

**J Code: J1437**

**4. Drug Order:**

- ☐ For patients less than 50 kg (110 lbs), administer one dose of Monoferric 20 mg/kg (\_\_\_\_\_ mg) IV
- ☐ For patients greater than 50 kg (110 lbs), administer one dose of Monoferric 1000 mg IV

**\*\*\* Intramed Plus may contact you to discuss other iron formulations based on patient's insurance coverage\*\*\***

**Adverse Drug Reaction Protocol:** Manage any adverse reaction that may occur per approved protocol.

**Pre-Medication Orders:** \_\_\_\_\_  
 No Pre-medications are recommended based on manufacturer guidelines.

By signing this form and utilizing these services, I am authorizing Intramed Plus to serve as my prior authorization agent with medical and pharmacy insurance providers.

**5. Physician Signature:** \_\_\_\_\_ / \_\_\_\_\_ **Date:** \_\_\_\_\_

Dispense as written

Substitution permitted

**Printed Physician's Name:** \_\_\_\_\_ **Contact Phone #:** \_\_\_\_\_

**FAX ALL INFORMATION**  
**CENTRAL FAX 803.999.1754**

**CENTRAL INTAKE PHONE**  
**803.999.1750**