

**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 Deficient Anemia ICD-10 Code: D50.9  
 \_\_\_\_\_ Iron Deficient 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: \_\_\_\_\_

<b>Patient Weight:</b> _____ lbs.
<b>Patient Height:</b> _____ 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 #: \_\_\_\_\_

<b>FAX ALL INFORMATION</b> <b>CENTRAL FAX 803.999.1754</b>	<b>CENTRAL INTAKE PHONE</b> <b>803.999.1750</b>
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