INTRAMED Plus
infusion services

PANHEMATIN®

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 ICD-10 Code):

Primary Diagnosis:

_____ Acute intermittent hepatic porphyria — ICD-10 Code: E80.21

_____ Lupus Nephritis — ICD-10 Code: M32.1

_____ Other: _____ — ICD-10 Code: _____

Allergies: _____ (or attach list)

3. Clinical Information — Please fax with Infusion Order Form:

Patient
Weight: _____ lbs.
Height: _____ in.

- Clinical Notes supporting primary diagnosis
- Recent Lab/Test Results including:
  - o Elevated urinary delta aminolevulinic acid (ALA) or porphobilnogen (PBG)
- Medication List
- For off-label prophylaxis use, provide documentation of reduced frequency or severity of attacks

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PANHEMATIN® (hemin for injection)

J Code: J1640

4. Drug Order:

❑ **Administer** _____ mg/kg intravenously over 30 minutes once daily for _____ day(s) Refills: _____

❑ **Administer** _____ mg/kg intravenously over 30 minutes once weekly for _____ week(s) Refills: _____

❑ **Other dosing:** _____ Refills: _____

*Recommended dosing: 1-4 mg/kg/day (max 6mg/kg/day). Flush vein with 100 mL NaCl post infusion.

Pre-Medication Orders: _____

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

By signing this form and utilizing our 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 with Credentials: _____ Phone #: _____

FAX ALL INFORMATION	CENTRAL INTAKE PHONE
CENTRAL FAX **803.999.1754**	**803.999.1750**