

**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 in chronic kidney disease ICD-10 Code: D63.1  
 \_\_\_\_\_ 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
- Medication List
- Infusion Center–Lab Orders (Check order for Infusion Center to manage):  
☐ \_\_\_\_\_

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

**VENOFER® (iron sucrose)**

J Code: J1756

**4. Drug Order:**

- ☐ Administer 200 mg IV on 5 different occasions within 14-day period  
 Doses Authorized: 5 (total cumulative dose: 1000 mg)
- ☐ Administer 300 mg IV on day 1 and again day 14, followed by a single 400 mg infusion day 28.  
 Doses Authorized: 3 (total cumulative dose: 1000 mg)
- ☐ Other: \_\_\_\_\_

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

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

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 with Credentials: \_\_\_\_\_ NPI: \_\_\_\_\_

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

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