

MEDICAL PHARMACY PRIOR AUTHORIZATION REQUEST FORM
INTRAVENOUS IRON THERAPY

Feraheme®, Ferrlecit®, INFed®, Injectafer®, Monoferric®, Venofer®

For authorization, please answer each question and fax this form PLUS chart notes back to the U of U Health Plans Prior Authorization Department at 801-213-1547. Failure to submit clinical documentation to support this request will result in delay and/or denial of the request.

If you have prior authorization questions, please call for assistance: Healthy U: 855-856-5694, University of Utah Health Employees: 855-856-5690, Individual & Family Plans: 855-869-4769, Commercial Groups: 855-859-4892, MHC: 855-885-7695, Advantage U Part B: 888-605-0858

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:	HCPCS Code:	

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Preferred: INFed® (iron dextran) Venofer® (iron sucrose)

Non-preferred: Feraheme® (ferumoxytol), Ferrlecit® (sodium ferric gluconate complex in sucrose), Injectafer® (ferric carboxymaltose), Monoferric® (ferric derisomaltose)

Dosing/Frequency: _____

If the request is for reauthorization, proceed to reauthorization section

Questions	Yes	No	Comments/Notes
1. Has the member been diagnosed with iron deficiency anemia?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
2. Has the member had a trial and failure to of oral iron therapy?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
3. Is the member losing iron from blood loss at a rate greater than they are able to absorb from the intestine?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
4. Does the member have a gastrointestinal disorder (e.g. ulcerative colitis, Crohn's disease) in which oral iron therapy may aggravate therapy?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
5. Is the member unable to maintain iron balance on hemodialysis?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
6. Is oral iron not able to reverse the deficiency quickly enough due to the severity of the anemia and/or presence of additional risk factors (e.g., pregnancy, severe heart failure)	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
7. Is the member donating large amounts of blood for autotransfusion programs?	<input type="checkbox"/>	<input type="checkbox"/>	
8. Is the anemia chemotherapy-induced?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation

REAUTHORIZATION

1. Is the request for reauthorization of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
---	--------------------------	--------------------------	--

Confidentiality Notice

This document and any accompanying document contain confidential information and is intended for the use of the individual or entity named on this transmission sheet. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or the taking of any action in reliance on the contents of this information is strictly prohibited and the document should be returned to this office immediately. If you have received this facsimile in error, please notify us by telephone immediately and destroy document received.

2. Does documentation show a continued medical necessity and clinically significant response to therapy?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			
Additional information:			
Physician's Signature:			

****Failure to submit clinical documentation to support this request will result in delay and/or denial of the request****

Policy PHARM- M002
 Origination Date: 01/25/2016
 Reviewed/Revised Date: 10/28/2020
 Next Review Date: 10/28/2021
 Current Effective Date: 11/01/2020

Confidentiality Notice

This document and any accompanying document contain confidential information and is intended for the use of the individual or entity named on this transmission sheet. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or the taking of any action in reliance on the contents of this information is strictly prohibited and the document should be returned to this office immediately. If you have received this facsimile in error, please notify us by telephone immediately and destroy document received.