

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

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

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), Ferrlecit® (sodium ferric gluconate complex in sucrose)

Non-preferred: Feraheme® (ferumoxytol), Injectafer® (ferric carboxymaltose), Monoferric® (ferric derisomaltose)

Dosing/Frequency: _____

If the request is for reauthorization, proceed to reauthorization section

Questions	Yes	No	Comments/Notes
1. Does the member have a serum ferritin concentration $\leq 100\text{ng/mL}$ and one of the following diagnoses: <ul style="list-style-type: none"> • heart failure • chronic kidney disease (CKD) • hereditary hemorrhagic telangiectasia (HHT) 	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
2. Is the member currently pregnant with a serum ferritin concentration $\leq 20\text{ng/mL}$	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
3. Has the member been diagnosed with iron deficiency anemia?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
4. Has the member had a trial and failure to of oral iron therapy?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
5. 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
6. 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
7. Is the member unable to maintain iron balance on hemodialysis?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation

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8. Is the member donating large amounts of blood for autotransfusion programs?	<input type="checkbox"/>	<input type="checkbox"/>	
9. 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"/>	
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
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