HEALTHY U CHIP

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 Healthy U CHIP Prior Authorization Department at 801-213-1547.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have medical pharmacy prior authorization questions, please call for assistance: 833-981-0212

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 ≤100ng/mL and one of the following diagnoses: • heart failure • chronic kidney disease(CKD) • hereditary hemorrhagic telangiectasia (HHT)	☐	☐	**Please provide documentation**
2. Is the member currently pregnant with a serum ferritin concentration ≤ 20ng/mL	☐	☐	**Please provide documentation**
3. Has the member been diagnosed with iron deficiency anemia?	☐	☐	**Please provide documentation**
4. Has the member had a trial and failure to of oral iron therapy?	☐	☐	**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?	☐	☐	**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?	☐	☐	**Please provide documentation**
7. Is the member unable to maintain iron balance on hemodialysis?	☐	☐	**Please provide documentation**
8. Is the member donating large amounts of blood for autotransfusion programs?	☐	☐	
9. Is the anemia chemotherapy-induced?	☐	☐	**Please provide documentation**

REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Does documentation show a continued medical necessity and clinically significant response to therapy?	☐	☐	**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:			

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Policy: PHARM-CHIP-M002
Origination Date: 07/01/2024
Reviewed/Revised Date:
Next Review Date:
Current Effective Date: 07/01/2024