State of Oklahoma
SoonerCare
Intravenous Iron Therapy Prior Authorization Form

Member Name:_____ ***Date of Birth:***_____ ***Member ID#:***_____

Drug Information

Medication Name:_____ ***Strength:***_____

Dose:_____ ***Regimen:***_____ ***Start Date:***_____

HCPCS code:_____ ***Billing Units Per Dose:*** _____

Billing Provider Information

Provider NPI:_____ ***Provider Name:***_____

Provider Phone: _____ ***Provider Fax:***_____

Prescriber Information

Prescriber NPI: _____ ***Prescriber Name:***_____

Prescriber Phone: _____ ***Prescriber Fax:***_____

Criteria

All information must be provided and SoonerCare may verify through further requested documentation.

1. Please indicate the diagnosis for which intravenous iron therapy is being prescribed:
   - ☐ Iron Deficiency Anemia
   - ☐ Iron Deficiency Anemia with Chronic Kidney Disease
   - ☐ Iron Deficiency with Heart Failure [Injectafer® (ferric carboxymaltose) requests only]
   - ☐ Other:_____
2. If member has chronic kidney disease, please provide the following information:
   a. Stage of chronic kidney disease:_____
   b. Is the member on dialysis? Yes☐ No☐
3. If the member's diagnosis includes iron deficiency anemia, please submit laboratory results verifying iron deficiency and anemia (iron labs in addition to hemoglobin or complete blood count).
4. Has the member had a trial of oral iron therapy? Yes☐ No☐
   a. If "Yes", please provide the following:
      i. Dates of the oral iron therapy trial:_____
      ii. Member's response to oral iron therapy:_____
   b. If "No", please provide a patient-specific, clinically significant reason why oral iron therapy is not appropriate for the member:_____
5. Has the member had a previous history of allergic reaction to any intravenous iron products? Yes☐ No☐
6. Has the member had a trial of Feraheme® (ferumoxytol), Infed® (iron dextran) or Venofer® (iron sucrose)? Yes☐ No☐
   a. If "Yes", please provide the following:
      i. Name of intravenous iron product(s) tried:_____
      ii. Dates of the intravenous iron trial(s):_____
      iii. Member's response to the intravenous iron trial(s)_____
   b. If "No", please provide a patient-specific, clinically significant reason why Feraheme®, Infed® and Venofer® are not appropriate for the member:_____

PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:	CONFIDENTIALITY NOTICE
University of Oklahoma College of Pharmacy Pharmacy Management Consultants Product Based Prior Authorization Unit Fax: 1-800-224-4014 Phone: 1-800-522-0114 Option 4	*This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.*

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7. For Injectafer®, if the member has iron deficiency with heart failure, please provide the following additional information:
   A. Does the member have New York Heart Association class II-III heart failure? Yes☐ No☐
   B. Will IV Iron therapy be used to improve exercise capacity? Yes☐ No☐
   C. Is the member receiving optimal background therapy for Heart Failure? Yes☐ No☐
   D. Does the member have left ventricular ejection fraction (LVEF) <45%? Yes☐ No☐
   E. Member's current weight: _____ Hemoglobin (Hb) (g/dL): _____ Date taken: _____
   F. Please submit laboratory results verifying iron deficiency.
   G. For maintenance doses at weeks 12, 24, and 36, please submit updated lab results verifying continued iron deficiency for each dose. Requests will be approved for (1) 500mg dose at a time.
8. For Monoferric®, please provide a patient-specific, clinically significant reason why the member cannot utilize all other forms of intravenous (IV) iron: _____

****Please note: Feraheme® (ferumoxytol), Infed® (iron dextran) and Venofer® (iron sucrose) are available without prior authorization****

Additional Information: _____

_____

_____

_____

Prescriber Signature: _____ **Date:** _____

I certify that the indicated treatment is medically necessary and all information is true and correct to the best of my knowledge.
Pease do not send in chart notes. Specific information will be requested if necessary. Failure to complete this form in full will result in processing delays.

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