Updated: 08/2021
DMMA Approved: 08/2021

Request for Prior Authorization for IV/Injectable Iron Medications
Website Form – www.highmarkhealthoptions.com
Submit request via: Fax - 1-855-476-4158

All requests for IV/Injectable Iron Medications require a prior authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

IV/Injectable Iron Medications Prior Authorization Criteria:
IV/Injectable Iron Medications addressed in this policy include: Injectafer (ferric carboxymaltose injection), Feraheme (ferumoxytol injection), Monoferric (ferric derisomaltose)

For all requests for IV/injectable iron medications all the following criteria must be met:

- Is age-appropriate according to FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature
- The member has a documented trial and failure or an intolerance or contraindication to low molecular weight iron dextran (Infed).
- The member has a documented trial and failure or intolerance of oral iron therapy or oral therapy would be inappropriate due to one of the following reasons:
    - TSAT < 12%
    - Hemoglobin (Hgb) < 7 g/dL
    - Severe or ongoing blood loss
    - Co-existing condition that would prevent absorption of oral iron therapy

Coverage may be provided with a diagnosis of iron deficiency anemia without chronic kidney disease and the following criteria is met:

- Member has laboratory documentation supporting one of the following:
    - Measured ferritin level is less than 15 mcg/L
    - Measured serum iron level and transferrin saturation level are below the laboratory's lower range of normal; **AND** measured total iron-binding capacity is above the laboratory's upper range of normal
- **Initial Duration of Approval:** 3 months
- **Reauthorization criteria**
    - Documentation showing a normalized hemoglobin (13.5 to 17.5 g per deciliter for men, 12.0 to 15.5 grams per deciliter for women)
        - If the member fails to reach normalized hemoglobin levels, a statement of medical necessity from the provider is required
    - Documentation of a co-existing condition that would prevent absorption of oral iron therapy, failure to transition patient to oral therapy, or provider justification for not attempting an additional trial of oral therapy.
- **Reauthorization Duration of approval:** 3 months for a total duration of 6 months
    - If the request is for a duration of therapy greater than 6 months, a statement of medical necessity from the provider is required

Coverage may be provided with a diagnosis of iron deficiency anemia with chronic kidney disease and the following criteria is met:

- Ferritin ≤ 500 ng/ml (≤ 500 mg/L)
- Transferrin saturation (TSAT) ≤ 30%
    - This requirement does not apply to patients on hemodialysis concurrently treated with an erythropoiesis stimulating agent
- For Injectafer and Monoferric only: member must be non-dialysis-dependent
- **Initial Duration of Approval:** 3 months
- **Reauthorization criteria**
    - Documentation of improved Hemoglobin (Hgb) from baseline **AND** Transferrin saturation (TSAT) ≤ 30% **AND** Ferritin ≤ 500 ng/ml (≤ 500 mg/L)
    - Documentation of a co-existing condition that would prevent absorption of oral iron therapy, failure to transition patient to oral therapy, or provider justification for not attempting an additional trial of oral therapy.
    - For Injectafer and Monoferric only: member must still be non-dialysis-dependent

Reauthorization Duration of approval: 12 months

Coverage may be provided for any non-FDA labeled indication if it is determined that the use is a medically accepted indication supported by nationally recognized pharmacy compendia or peer-reviewed medical literature for treatment of the diagnosis(es) for which it is prescribed. These requests will be reviewed on a case by case basis to determine medical necessity.

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IV IRON MEDICATION PRIOR AUTHORIZATION FORM

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Highmark Health Options Pharmacy Services. **FAX:** (855) 476-4158
If needed, you may call to speak to a Pharmacy Services Representative.
PHONE: (844) 325-6251 Monday through Friday 8:00am to 7:00pm

PROVIDER INFORMATION

Requesting Provider:	NPI:
Provider Specialty:	Office Contact:
Office Address:	Office Phone:
	Office Fax:

MEMBER INFORMATION

Member Name:	DOB:
Health Options ID:	Member weight: _____pounds or _____kg

REQUESTED DRUG INFORMATION

Medication:	Strength:
Frequency:	Duration:
Is the member currently receiving requested medication? ☐ Yes ☐ No	Date Medication Initiated:

Is this medication being used for a chronic or long-term condition for which the medication may be necessary for the life of the patient? ☐ Yes ☐ No

Billing Information

This medication will be billed: ☐ at a pharmacy **OR**
☐ medically (if medically please provide a JCODE:_____

Place of Service: ☐ Hospital ☐ Provider's office ☐ Member's home ☐ Other

Place of Service Information

Name:	NPI:
Address:	Phone:

MEDICAL HISTORY (Complete for ALL requests)

Diagnosis: _____

Please check all applicable boxes:
☐ Patient has severe or ongoing blood loss
☐ Patient has chronic kidney disease, is on hemodialysis, and is being treated with erythropoiesis stimulating agents
☐ Patient has chronic kidney disease and is non-dialysis-dependent

Does the patient have a co-existing condition that would prevent absorption of oral iron therapy? ☐ Yes ☐ No
If Yes, please specify: _____

LABORATORY VALUES

Lab	Initial (Pre-Treatment) Level	Reference Range	Date	Post-Therapy Level (Reauthorization only)	Reference Range	Date
Transferrin saturation (TSAT)						
Hemoglobin (Hgb)						
Serum Iron						
Ferritin						
Total Iron-Binding Capacity						

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IV IRON MEDICATION
PRIOR AUTHORIZATION FORM (CONTINUED) – PAGE 2 OF 2

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MEMBER INFORMATION

Member Name:	DOB:
Health Options ID:	Member weight: _____pounds or _____kg

CURRENT or PREVIOUS THERAPY

Medication Name	Strength/ Frequency	Dates of Therapy	Status (Discontinued & Why/Current)

REAUTHORIZATION

Has the patient attempted an additional trial of oral iron therapy? ☐ Yes ☐ No
If No, please specify: _____
If Yes, did the patient fail to respond? ☐ Yes ☐ No

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature	Date