Updated: 02/2025
DMMA Approved: 02/2025

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

Requests for the IV/Injectable Iron Medications Injectafer (ferric carboxymaltose injection), Feraheme (ferumoxytol injection), and Monoferric (ferric derisomaltose) require a Prior Authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Prior Authorization Criteria:

For all requests the following criteria must be met:

- The requested dose and frequency is in accordance with FDA-approved labeling, nationally recognized compendia, and/or evidence-based practice guidelines
- 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 iron dextran (Infed), iron sucrose (Venofer), or sodium ferric gluconate (Ferrlecit).
- 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 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.

Drugs are authorized in generic form unless the branded product is on the preferred drug list or the prescriber has indicated in writing that the branded product is medically necessary. If only the branded product is on the preferred drug list, the generic form will be considered non-preferred and shall not require the prescriber to indicate in writing that the branded product is medically necessary.

HIGHMARK HEALTH OPTIONS

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IV/INJECTABLE IRON MEDICATIONS: INJECTAFER, FERAHEME, MONOFERRIC
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 Mon – Fri 8 am to 7 pm

PROVIDER INFORMATION

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

MEMBER INFORMATION

Member Name:	DOB:	
Member ID:	Member weight:	Height:

REQUESTED DRUG INFORMATION

Medication:	Strength:	
Directions:	Quantity:	Refills:
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, 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:	ICD Code:

Has iron dextran (Infed), iron sucrose (Venofer) or sodium ferric gluconate (Ferrlecit) been tried? ☐ Yes (list below) ☐ No

Has oral iron therapy been tried? ☐ Yes ☐ No

If **No**, please indicate if any of the following apply:

- Does the patient have a co-existing condition that would prevent absorption of oral iron therapy? ☐ Yes ☐ No
  If yes, please specify: _____
- Does the member have severe or ongoing blood loss? ☐ Yes ☐ No
- Is TSAT < 12%? ☐ Yes ☐ No
- Is Hemoglobin (Hgb) < 7 g/dL? ☐ Yes ☐ No

CURRENT or PREVIOUS THERAPY

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

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature	Date