

IRON, PARENTERAL
PRIOR AUTHORIZATION FORM

To review the prior authorization guidelines for these agents, please refer to the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapter – Iron, Parenteral at: <http://www.dhs.state.pa.us/publications/bulletinsearch/index.htm>

PRIOR AUTHORIZATION REQUEST INFORMATION

New Renewal Additional Information

For Additional Information: Coordinator Name: _____ PA#: _____

Number of Pages in this Request: _____ Office Contact Name: _____ & Phone: (_____) _____

RECIPIENT INFORMATION

Name: _____ Recipient ID#: _____ Date of Birth: _____

PRESCRIBER INFORMATION

Prescriber Name: _____ Specialty: _____

NPI#: _____ OR MA Provider ID#: _____ State License#: _____

Prescriber Address: _____ Suite #: _____

City/State/Zip: _____ Phone: (_____) _____ Fax: (_____) _____

MEDICAL INFORMATION

Drug Requested: Dexferrum Feraheme Injectafer Venofer

Strength: _____ **Dose:** _____ **Total Number of Doses:** _____

Diagnosis: _____ **Diagnosis Code:** _____ (required)

Height: _____ inches / centimeters **Weight:** _____ pounds / kilograms

1. What is the indication for parenteral iron replacement (check & submit supporting documentation)?

- Iron-deficiency anemia
- Chemotherapy-induced anemia
- Blood loss
- Other: _____

2. Does the Recipient have results for the following labs (check all that apply & submit documentation)?

- Hemoglobin
- Hematocrit
- Iron Level
- Ferritin
- Total Iron Binding Capacity (TIBC)

3. Does the Recipient have a diagnosis of Chronic Kidney Disease? Yes (submit documentation) No

4. Is the Recipient receiving dialysis? Yes (submit documentation of dialysis schedule) No

5. Has the Recipient tried and failed (or have a contraindication or intolerance to) any of the following (check all that apply & submit documentation)? Ferrlecit InFed Sodium ferric gluconate Oral iron supplementation

PLEASE SEND COMPLETED FORM WITH CLINICAL INFORMATION TO DHS – PHARMACY DIVISION

Prescriber Signature: _____ **Date:** _____

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