



MEDICARE FORM

Feraheme® (ferumoxylol) and
Injectafer® (ferric carboxymaltose)
Medication Precertification Request

Page 1 of 2

(All fields must be completed and legible for Precertification Review)

For Medicare Advantage Part B:

Phone: 1-866-503-0857

FAX: 1-844-268-7263

For other lines of business:

Please use other form.

Note: Feraheme, Injectafer, and Monoferric are non-preferred.
The preferred products are Ferrlecit (sodium ferric gluconate), Infed, and Venofer.

Please indicate: [] Start of treatment: Start date ___/___/___
[] Continuation of therapy, Date of last treatment ___/___/___

Precertification Requested By: _____ Phone: _____ Fax: _____

A. PATIENT INFORMATION

Form section A containing fields for Patient Information: First Name, Last Name, DOB, Address, City, State, ZIP, Home Phone, Work Phone, Cell Phone, Email, Patient Current Weight, Patient Height, Allergies.

B. INSURANCE INFORMATION

Form section B containing fields for Insurance Information: Aetna Member ID #, Group #, Insured, Medicare status, Medicaid status, and other coverage questions.

C. PRESCRIBER INFORMATION

Form section C containing fields for Prescriber Information: First Name, Last Name, Address, City, State, ZIP, Phone, Fax, St Lic #, NPI #, DEA #, UPIN, Office Contact Name, and Specialty.

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Form section D containing fields for Dispensing Provider/Pharmacy: Place of Administration (Self-administered, Physician's Office, Outpatient Infusion Center, Home Infusion Center, Administration code(s)), and Dispensing Provider/Pharmacy details (Physician's Office, Retail Pharmacy, Specialty Pharmacy, Other, Name, Address, City, State, ZIP, Phone, Fax, TIN, PIN, NPI).

E. PRODUCT INFORMATION

Form section E containing fields for Product Information: Request is for (Feraheme, Injectafer), Dose, and Frequency.

F. DIAGNOSIS INFORMATION - Please indicate primary ICD code and specify any other where applicable.

Form section F containing fields for Diagnosis Information: Primary ICD Code, Secondary ICD Code, and Other ICD Code.

G. CLINICAL INFORMATION - Required clinical information must be completed in its entirety for all precertification requests.

Form section G containing clinical information: For All Requests (clinical documentation required for all requests), Note: Feraheme, Injectafer, and Monoferric are non-preferred, and a series of Yes/No questions regarding patient history and contraindications.

Continued on next page



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| | | | |
|--------------------|-------------------|---------------|-------------|
| Patient First Name | Patient Last Name | Patient Phone | Patient DOB |
|--------------------|-------------------|---------------|-------------|

G. CLINICAL INFORMATION (continued) – Required clinical information must be completed in its entirety for all precertification requests.

Please indicate the patient's serum ferritin level: _____

Please indicate the patient's transferrin saturation (TSAT) level: _____

Yes No Was the serum ferritin and/or transferrin saturation level drawn within the last 30 days?

Yes No Is this a request for continuation of therapy?

→ Yes No Does the patient have a contraindication, intolerance or ineffective response to Ferlecit, Infed, or Venofer?

For chronic kidney disease indications only:

Yes No Does the patient have iron deficiency anemia associated with chronic kidney disease?

Yes No Is the patient non-dialysis dependent (NDD) or undergoing peritoneal dialysis?

→ Please explain: The patient is non-dialysis dependent (NDD) The patient is undergoing peritoneal dialysis

For all other non- chronic kidney disease indications:

The patient is unable to tolerate oral iron compounds

The patient is losing iron (blood) at a rate that is too rapid for oral intake to compensate for the loss

The patient has a gastrointestinal tract disorder, such as inflammatory bowel disease (ulcerative colitis, and Crohn's disease) that may be aggravated by oral iron therapy

The patient is unable to maintain iron balance on treatment with hemodialysis

The patient is donating large amounts of blood for autologous programs

The patient has failed to heed instructions for oral iron supplementation or are incapable of accepting or following them

The patient has heart failure and iron deficiency with or without anemia

The patient has iron deficiency and chemotherapy-induced anemia

The patient has iron deficiency anemia due to heavy uterine bleeding

The patient has iron deficiency following gastric bypass surgery and/or subtotal gastric resection and who exhibited decreased absorption of oral iron

H. ACKNOWLEDGEMENT

Request Completed By (Signature Required): _____ Date: ____/____/____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The plan may request additional information or clarification, if needed, to evaluate requests.