MEDICARE FORM
Feraheme® (ferumoxytol) and Injectafer® (ferric carboxymaltose) Monoferric® (ferric derisomaltose) Medication Precertification Request

(All fields must be completed and legible for precertification review.)

For Medicare Advantage Part B:
For other lines of business:
Please use commercial form.

Note: Feraheme, Injectafer, and Monoferric are non-preferred. The preferred products are Ferrlecit (sodium ferric gluconate), Infed (iron dextran), and Venofer (iron sucrose). The preferred products do not require precertification.

Would you like to use electronic prior authorization? Consider using **Availity**, our electronic prior authorization portal. Learn more about **Availity** from the links in the table below.

For phone or fax requests, refer to the table below for routing information. To determine which box to use, refer to the patient's Aetna ID card. State specific special needs and Medicare-Medicaid Plans may be designated on the front of the ID card or in the website URL on the back of the card. If you don't see your specific plan listed, call the number on the back of the member's ID card to confirm routing information.

For Aetna Medicare Advantage and **Allina Health Aetna Medicare Members** send request to: **Phone:** 1-866-503-0857 **(TTY:** 711**)** **Fax:** 1-844-268-7263 **Availity:** https://www.aetna.com/health-care-professionals/resource-center/availity.html
For Aetna Medicare FIDE (HMO-DSNP) **Virginia Dual Eligible Special Needs Plans** send request to: **Phone:** 1-855-463-0933 **Fax:** 1-833-280-5224 **Availity:** https://www.aetnabetterhealth.com/virginia-hmosnp/providers/portal
For Aetna Medicare FIDE (HMO-DSNP) **New Jersey Dual Eligible Special Needs Plans** send request to: **Phone:** 1-844-362-0934 **Fax:** 1-833-322-0034 **Availity:** https://www.aetnabetterhealth.com/new-jersey-hmosnp/providers/portal.html
For Aetna Medicare FIDE (HMO D-SNP) **Illinois Dual Eligible Special Needs Plans** send request to: **Phone:** 1-866-600-2139 **FAX:** 1-855-320-8445 **Availity:** https://www.aetnabetterhealth.com/illinois/providers/portal
For Aetna Medicare HIDE (HMO D-SNP) **Michigan Dual Eligible Special Needs Plans** send request to: **Phone:** 1-855-676-5772 **Fax:** 1-844-241-2495 **Availity:** https://www.aetnabetterhealth.com/michigan/providers/portal.html

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Please indicate: ☐ Start of treatment: Start date ____/____/____
☐ Continuation of therapy, Date of last treatment ____/____/____

Precertification Requested By: _____ Phone: _____ Fax: _____

A. PATIENT INFORMATION

First Name:	Last Name:		DOB:
Address:	City:	State:	ZIP:
Home Phone:	Work Phone:	Cell Phone:	Email:
Patient Current Weight: ____ lbs or ____ kgs Patient Height: ____ inches or ____ cms			Allergies:

B. INSURANCE INFORMATION

Aetna Member ID #: _____
Group #: _____
Insured:

Does patient have other coverage? ☐ Yes ☐ No
If yes, provide ID#: _____ Carrier Name: _____
Insured:

Medicare: ☐ Yes ☐ No If yes, provide ID #: **Medicaid:** ☐ Yes ☐ No If yes, provide ID #:

C. PRESCRIBER INFORMATION

First Name:		Last Name: *(Check One):* ☐ M.D. ☐ D.O. ☐ N.P. ☐ P.A.			
Address:		City:		State:	ZIP:
Phone:	Fax:	St Lic #:	NPI #:	DEA #:	UPIN:
Provider Email:		Office Contact Name:		Phone:	

Specialty *(Check one):* ☐ **Hematologist** ☐ **Internal Medicine** ☐ **Other**: _____

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:
☐ Self-administered ☐ Physician's Office
☐ Outpatient Infusion Center Phone: _____
Center Name: _____
☐ Home Infusion Center Phone: _____
Agency Name: _____
Address: _____
City: _____ State: _____ ZIP: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____
NPI: _____

Dispensing Provider/Pharmacy: *Patient Selected choice*
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Other
Name: _____
Address: _____
City: _____ State: _____ ZIP: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____
NPI: _____

E. PRODUCT INFORMATION

Request is for: ☐ **Feraheme** ☐ **Injectafer** ☐ **Monoferric** **HCPCS Code:** _____

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

Primary ICD Code: ☐ _____ **Secondary ICD Code :** _____ **Other ICD Code:** _____

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

For All Requests (clinical documentation required for all requests):

Note: Feraheme, Injectafer, and Monoferric are non-preferred. The preferred products are Ferrlecit (sodium ferric gluconate), Infed (iron dextran), and Venofer (iron sucrose). The preferred products do not require prior authorization.

☐ Yes ☐ No Has the patient received a dose of the requested product through insurance in the last 365 days?
This does not include samples or doses administered without prior authorization.

☐ No Has the patient had a documented inadequate response to two or more of the following? (if yes, select all that apply below)
Medical records (e.g., chart notes) documenting an inadequate response to two or more preferred products must be available upon request.
☐ Ferrlecit (sodium ferric gluconate) ☐ Infed (iron dextran) ☐ Venofer (iron sucrose)
→ When was the member's inadequate response to the preferred drug? _____
→ Please describe the nature of the inadequate response to the preferred drug _____

☐ No Has the patient had a documented intolerable adverse event to two or more of the following? (if yes, select all that apply below)
Medical records (e.g., chart notes) documenting an intolerable adverse event to two or more preferred products must be available upon request.
☐ Ferrlecit (sodium ferric gluconate) ☐ Infed (iron dextran) ☐ Venofer (iron sucrose)
→ When was the member's intolerable adverse event to the preferred drug? _____
→ Please describe the nature of the intolerable adverse event to the preferred drug _____

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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 explain if there are any contraindications or other medical reason(s) that the patient cannot use any of the following preferred products when indicated for the patient's diagnosis (select all that apply).

☐ Ferrlecit (sodium ferric gluconate) ☐ Infed (iron dextran) ☐ Venofer (iron sucrose)

_____

_____

☐ Yes ☐ No Is the requested medication reasonable and necessary.

☐ Yes ☐ No Does the patient have a contraindication to the use of the requested medication as listed in the medication's prescribing information?

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.