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:
FAX: 1-844-268-7263
PHONE: 1-866-503-0857 **(TTY:** 711**)**

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

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: _____
☐ Administration code(s) (CPT): _____
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** **Dose:** _____ **Frequency:** _____
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, and Venofer.

☐ Yes ☐ No Has the patient had prior therapy with Feraheme (ferumoxytol injection) within the last 365 days?
☐ Yes ☐ No Has the patient had prior therapy with Injectafer (ferric carboxymaltose injection) within the last 365 days?
☐ Yes ☐ No Has the patient had prior therapy with Monoferric (ferric derisomaltose injection) within the last 365 days?
☐ Yes ☐ No Has the patient had a trial and failure, intolerance, or contraindication to any of the following? (select all that apply)
☐ Ferrlecit (sodium ferric gluconate) ☐ Infed (iron dextran) ☐ Venofer (iron sucrose)

Please explain if there are any 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)

_____
_____

Continued on next page

aetna®

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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 Ferrlecit, 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.