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

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

Aetna Precertification Notification
Phone: 1-866-752-7021
FAX: 1-888-267-3277

For Medicare Advantage Part B:
Phone: 1-866-503-0857
FAX: 1-844-268-7263

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

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

E. PRODUCT INFORMATION

Request is for: ☐ **Feraheme** ☐ **Injectafer**
Dose: _____ **Frequency:** _____

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):
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

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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.

- ☐ 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.