AvMed

MEDICAL PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-877-535-1391**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If information provided is not complete, correct, or legible, authorization can be delayed**.

For Medicare Members: Medicare Coverage for outpatient (Part B) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals. In addition, National Coverage Determination (NCD) and Local Coverage Determinations (LCDs) may exist and compliance with these policies is required where applicable. They can be found at: https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx. Additional indications may be covered at the discretion of the health plan.

Non-Preferred Parenteral Iron Products

Drug Requested: (select **ONE** of drugs below) **(Medical)**

PREFERRED **No prior authorization required**			
❑ **Feraheme®** (ferumoxytol) **(For ESRD on Dialysis) Q0139**	❑ **Ferrlecit®** (sodium ferric gluconate complex) **J2916**	❑ **INFeD®** (iron dextran) **J1750**	❑ **Venofer®** (iron sucrose) **J1756**
NON-PREFERRED **Prior authorization required as noted below**			
❑ **Feraheme®** (ferumoxytol) **(Non-ESRD) Q0138**	❑ **Injectafer®** (ferric carboxymaltose) **J1439**	❑ **Monoferric®** (ferric derisomaltose) **J1437**	

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member AvMed #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

NPI #: _____

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DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight (if applicable): _____ **Date weight obtained:** _____

❑ Standard Review. In checking this box, the timeframe does not jeopardize the life or health of the member or the member's ability to regain maximum function and would not subject the member to severe pain.

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

Length of Authorization: 2 months

Diagnosis – Select ONE of the following diagnoses below:

❑ Diagnosis: Iron-deficiency anemia

- ❑ Provider has submitted the following labs collected within the last 30 days:
  - ❑ Serum ferritin (iron) **AND** total iron binding capacity (TIBC)
  - ❑ Transferrin saturation (TSAT%) ***Note**: TSAT% = (Serum iron/TIBC) x 100%
- ❑ Lab documentation show member's TSAT < 20%
- ❑ Provider has submitted documentation to confirm member has tried and failed **ONE** of the following preferred parenteral iron preparations
  - ❑ Feraheme® (ferumoxide) for ESRD on Dialysis
  - ❑ Ferrlecit® (sodium ferric gluconate complex)
  - ❑ INFeD® (iron dextran)
  - ❑ Venofer® (iron sucrose)

❑ Diagnosis: Moderate-to-severe restless leg syndrome (RLS)

- ❑ Member is 18 years of age and older
- ❑ Provider has submitted the following labs collected within the last 30 days:
  - ❑ Serum ferritin (iron) **AND** total iron binding capacity (TIBC)
  - ❑ Transferrin saturation (TSAT%) ***Note**: TSAT% = (Serum iron/TIBC) x 100%
- ❑ Lab documentation shows member's TSAT <20% after trial of an oral iron supplement

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- ❑ Member has tried and had an unsatisfactory response, intolerance or contraindication to oral iron administration
- ❑ Provider has submitted documentation to confirm member has tried and failed **ONE** of the following preferred parenteral iron preparations
  - ❑ Feraheme® (ferumoxytol) for ESRD on Dialysis
  - ❑ Ferrlecit® (sodium ferric gluconate complex)
  - ❑ INFeD® (iron dextran)
  - ❑ Venofer® (iron sucrose)

❑ Diagnosis: Management of cancer and chemotherapy-induced anemia

- ❑ Provider has submitted the following labs collected within the last 30 days:
  - ❑ Serum ferritin (iron) **AND** total iron binding capacity (TIBC)
  - ❑ Transferrin saturation (TSAT%) ***Note**: TSAT% = (Serum iron/TIBC) x 100%
- ❑ Provider has submitted documentation to confirm member has tried and failed **ONE** of the following preferred parenteral iron preparations
  - ❑ Feraheme® (ferumoxytol) for ESRD on Dialysis
  - ❑ Ferrlecit® (sodium ferric gluconate complex)
  - ❑ INFeD® (iron dextran)
  - ❑ Venofer® (iron sucrose)
- ❑ Member has functional iron deficiency and must meet **ONE** of the following:
  - ❑ Member has a TSAT < 50% with the goal of avoiding allogenic transfusion
  - ❑ Member has a TSAT < 50% and requested medication will be used in combination with erythropoises-stimulating agents (ESAs)

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Medication being provided by: Please check applicable box below.

- ❑ **Location/site of drug administration:** _____

  NPI or DEA # of administering location: _____

  OR

- ❑ **Specialty Pharmacy**

For urgent reviews: Practitioner should call Sentara Health Pre-Authorization Department if they believe a standard review would subject the member to adverse health consequences. Sentara Health's definition of urgent is a lack of treatment that could seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.

***Approved by Pharmacy and Therapeutics Committee: 3/27/2025**
REVISED/UPDATED: 6/11/2025