

Intravenous Iron Drug Use Criteria

Created: 7/2023

Revised:

Includes:

<i>InFed</i>	Iron Dextran
<i>Ferrlecit</i>	Sodium Ferric Gluconate
<i>Feraheme</i>	Ferumoxytol
<i>Injectafer</i>	Ferric Carboxymaltose
<i>Monoferic</i>	Ferric Derisomaltose

****Venofer* (Iron Sucrose) does not require a Prior Authorization***

1. Does the member have a diagnosis of iron deficiency anemia confirmed by the following labs: hemoglobin <13g/dL (males) or <12g/dL (females) **AND** Ferritin <100 ng/ml OR TSAT <20% within the last 30 days?
 - a. If yes, go to 3
 - b. If no, go to 2
2. Does the member have a diagnosis of iron deficiency without anemia confirmed by the following labs: normal hemoglobin (>13 g/dL for males or >12 g/dL for females) **AND** Ferritin <30 ng/ml (<100 ng/ml in heart failure) OR TSAT <20% within the last 30 days?
 - a. If yes, go to 3
 - b. If no, deny as not meeting criteria. Oral iron is on formulary through the pharmacy benefit.
3. Has the member failed or have a contraindication to *Venofer* (iron sucrose) or is their documentation that the dosing schedule of *Venofer* would be a barrier?
 - a. If yes, go to 4
 - b. If no, deny as nonformulary. Formulary alternative is iron sucrose.
4. Is the request for *Feraheme* (ferumoxytol), *Ferrlecit* (sodium ferric gluconate), or *InFed* (iron dextran)?
 - a. If yes, approve for requested duration (up to a maximum of 12 months)
 - b. If no, go to 5
5. Is the request for *Injectafer* (ferric carboxymaltose) or *Monoferic* (ferric derisomaltose) and the member has failed or have contraindications to *Feraheme* (ferumoxytol), *Ferrlecit* (sodium ferric gluconate), and *InFed* (iron dextran)?
 - a. If yes, approve for requested duration (up to a maximum of 12 months)

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- b. If no, deny as not meeting criteria. Request trial of the following: Feraheme (ferumoxytol), Ferrlecit (sodium ferric gluconate), and InFed (iron dextran)