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Intravenous Iron Drug Use Criteria

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Revised:

Includes:

InFed Iron Dextran

Ferrlecit Sodium Ferric Gluconate

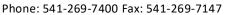
Feraheme Ferumoxytol

Injectafer Ferric Carboxymaltose
Monoferric Ferric Derisomaltose

Venofer (Iron Sucrose) does not require a Prior Authorization

- Does the member have a diagnosis of iron deficiency anemia confirmed by the following labs: hemoglobin <13g/dL (males) or <12g/dL (females) <u>AND</u> 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 Monoferric (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)







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