State of Oklahoma SoonerCare
Intravenous Iron Therapy Prior Authorization Form

OKLAHOMA Health Care Authority | SoonerSelect | aetna

Member Name:_____ ***Date of Birth:***_____ ***Member ID#:***_____

Drug Information

Medication Name:_____ ***Strength:***_____

Dose:_____ ***Regimen:***_____ ***Start Date:***_____

HCPCS code:_____ ***Billing Units Per Dose:*** _____

Billing Provider Information

Provider NPI:_____ ***Provider Name:***_____

Provider Phone: _____ ***Provider Fax:***_____

Prescriber Information

Prescriber NPI: _____ ***Prescriber Name:***_____

Prescriber Phone: _____ ***Prescriber Fax:***_____

Criteria

All information must be provided and SoonerCare may verify through further requested documentation.

1. Please indicate the diagnosis for which intravenous iron therapy is being prescribed:
   - ☐ Iron Deficiency Anemia
   - ☐ Iron Deficiency Anemia with Chronic Kidney Disease
   - ☐ Other:_____
2. If member has Chronic Kidney Disease, please provide the following information:
   a. Stage of Chronic Kidney Disease:_____
   b. Is the member on dialysis? Yes☐ No☐
3. Please submit laboratory results verifying Iron Deficiency Anemia
4. Has the member had a trial of oral iron therapy? Yes☐ No☐
   a. If "Yes", please provide the following:
      i. Dates of the oral iron therapy trial:_____
      ii. Member's response to oral iron therapy:_____
   b. If "No", please provide a patient-specific, clinically significant reason why oral iron therapy is not appropriate for the member:_____
5. Has the member had a previous history of allergic reaction to any intravenous iron products? Yes☐ No☐
6. Has the member had a trial of Infed® (iron dextran) or Venofer® (iron sucrose)? Yes☐ No☐
   a. If "Yes", please provide the following:
      i. Name of intravenous iron product(s) tried:_____
      ii. Dates of the intravenous iron trial(s):_____
      iii. Member's response to the intravenous iron trial(s)_____
   b. If "No", please provide a patient-specific, clinically significant reason why Infed® or Venofer® is not appropriate for the member:_____

****Please note: Infed® (iron dextran) and Venofer® (iron sucrose) are available without prior authorization****

Prescriber Signature: _____ **Date:** _____

I certify that the indicated treatment is medically necessary and all information is true and correct to the best of my knowledge.
Pease do not send in chart notes. Specific information will be requested if necessary. Failure to complete this form in full will result in processing delays.

Fax completed prior authorization request form to 888-601-8461 or submit Electronic Prior Authorization throughCoverMyMeds® or SureScripts. All requested data must be provided. Incomplete forms or forms without the chart notes will be returned. Pharmacy Coverage Guidelines are available at AetnaBetterHealth.com/Oklahoma	CONFIDENTIALITY NOTICE *This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.*