# State of Oklahoma
# Oklahoma Health Care Authority
# Intravenous Iron Therapy Prior Authorization Request

***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 Iron Dextran? Yes[ ] No[ ] **(Iron Dextran is available without prior authorization)**
   a. If "Yes", please provide the following:
      i. Dates of the Iron Dextran trial:_____
      ii. Member's response to Iron Dextran:_____
   b. If "No", please provide a patient-specific, clinically significant reason why Iron Dextran is not appropriate for the member:_____

**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.*

| PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO: | CONFIDENTIALITY NOTICE |
|---|---|
| University of Oklahoma College of Pharmacy<br>Pharmacy Management Consultants<br>Product Based Prior Authorization Unit<br>Fax: 1-800-224-4014<br>Phone: 1-800-522-0114 Option 4 | *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.* |