pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

IRON, PARENTERAL PRIOR AUTHORIZATION FORM

- **Please submit all requested documentation with this request. Incomplete documentation may delay the processing of this request.**
- To review the prior authorization guidelines for Parenteral Iron agents, please refer to the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapter – **Iron, Parenteral** (accessible at: http://www.dhs.pa.gov/provider/pharmacyservices/drugsrequiringclinicalpriorauthorization/index.htm).

PRIOR AUTHORIZATION INFORMATION		PRESCRIBER INFORMATION	
☐New request ☐Renewal request	Total # of pages: _______	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		State license #:	
LTC facility contact/phone:		NPI:	MA Provider ID#:
RECIPIENT INFORMATION		Street address:	
Recipient Name:		Suite #:	City/state/zip:
Recipient ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Non-preferred medication requested: ☐Feraheme vial ☐ Injectafer vial

Strength:	Dose & frequency:	Total # of doses:	Height:	Weight:

Diagnosis (*submit documentation*):	DX code (*required*):

1. What is the indication for parenteral iron replacement? *Check indication and submit supporting documentation.*
   ☐blood loss ☐iron-deficiency anemia
   ☐chemotherapy-induced anemia ☐other: ____________________

Question	Response
2. Does the recipient have a history of trial and failure, contraindication, or intolerance of the preferred Parenteral Iron agents? *Check all that apply.* ☐Ferrlecit ☐sodium ferric gluconate complex ☐Infed ☐Venofer	☐Yes – *Submit all supporting documentation of preferred agent tried and treatment outcome, including contraindications or intolerances.* ☐No
3. Does the recipient have a history of trial and failure, contraindication, or intolerance of oral iron supplementation?	☐Yes – *Submit supporting documentation.* ☐No

4. *Submit documentation* of recent results for the following lab tests. *Check all lab results that are included.*
   ☐ferritin ☐hemoglobin ☐total iron binding capacity (TIBC)
   ☐hematocrit ☐iron level

Question	Response
5. Does the recipient have a diagnosis of chronic kidney disease?	☐Yes – *Submit supporting documentation.* ☐No
6. Is the recipient receiving dialysis?	☐Yes – *Submit documentation of dialysis schedule.* ☐No

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	**Date**:

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