AdvancedHealth
Bridging the Future of Healthcare

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Intravenous Iron Drug Use Criteria

Created: 7/2023
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***

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 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)

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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)