Washington State Health Care Authority

Clear Form

IV Iron

Please provide the information below. Please print your answer, attach supporting documentation, sign, date, and return to our office as soon as possible to expedite this request. **Without this information, we may deny the request in 30 days.**

A typed and completed *General Authorization for Information* form (13-835) must be attached to your request.
Fax to: 1-866-668-1214

DATE OF REQUEST	PATIENT	DATE OF BIRTH	PROVIDERONE CLIENT ID

PRESCRIBER	BILLING PROVIDER NPI NUMBER	TELEPHONE NUMBER	FAX NUMBER

1. Which intravenous iron product is being requested?
   - ☐ Iron sucrose (Venofer). Max dosing: 1000mg/per treatment
   - ☐ Sodium ferric gluconate (Ferrlecit). Max dosing: 1000mg/ per treatment
   - ☐ Ferumoxytol (Feraheme). Max dosing: 1020mg/ per treatment
   - ☐ Ferric carboxymaltose (Injectafer). Max dosing: 1500mg/ per treatment
   - ☐ Iron dextran (INFeD). Max dosing: 1000mg/ per treatment
   - ☐ Other. Specify:

2. Is requested treatment within max dosing as listed above? ☐ Yes ☐ No
   If no, what is the requested dosing/duration?

3. What is the diagnosis for which the above product is being requested?
   - ☐ Iron deficiency anemia associated with (please specify)
     - ☐ Chronic kidney disease (defined as <60 mL/min GFR)
       - ☐ Non-dialysis dependent
       - ☐ Dialysis dependent
     - ☐ Pregnancy
     - ☐ Heart failure
     - ☐ Cancer or chemotherapy-induced anemia
     - ☐ Intolerance or incomplete response to oral iron therapy
   - ☐ Other. Specify:

4. Has oral iron therapy been tried? ☐ Yes ☐ No
   If yes:
   - What was the formulation? _____
   - What was the dosage? _____
   - What was the duration? _____

   If no, please explain why oral iron therapy cannot be tried? _____

5. What are the following lab values (please also attach lab reports):

   Hemoglobin _____ Hematocrit _____ Ferritin level _____ Total Iron _____

CHART NOTES AND LAB REPORTS ARE REQUIRED

PRESCRIBER'S SIGNATURE	PRESCRIBER'S SPECIALTY	DATE