SecurityHealth Plan℠
Promises kept, plain and simple.®

1515 North Saint Joseph Avenue
PO Box 8000
Marshfield, WI 54449-8000

1.800.472.2363 | 715.221.9555
TTY: 711

Intravenous Iron Therapy

Prior Authorization Request

Date _____

Member information		
Member name (print)	SMID	Date of birth (month/day/year)
Provider information		
Provider name (print)	Telephone number	Fax number
Place of service: ☐ Ambulatory Surgery Center ☐ Hospital outpatient ☐ Hospital inpatient ☐ Provider's office ☐ Other _____		
Facility where services will be provided (include address if the provider provides services at more than one practice location)		
Contact person name (print)	Telephone number	Fax number
Procedure information		
Scheduled date of service (month/day/year) / Requested service/procedure		Procedure code(s)
Diagnosis	Diagnosis code(s)	

Answer all of the following questions.

No prior authorization is required if the iron infusion is for one of the following medications: iron sucrose (Venofer®), ferric gluconate (Ferrlecit®) and iron dextran (Infed®).

Is the iron infusion for one of these medications:

– Ferumoyxtol (Feraheme®) ..... ☐ Yes ☐ No

– Ferric carboxymaltose (Injectafer®) ..... ☐ Yes ☐ No

– Ferric pyrophosphate citrate (Triferic®) ..... ☐ Yes ☐ No

– Or other IV iron agents ..... ☐ Yes ☐ No

If yes, what medication _____

Has the member had an inadequate response to two of these agents:
iron sucrose (Venofer®), ferric gluconate (Ferrlecit®) and iron dextran (Infed®) ..... ☐ Yes ☐ No

Does the member have any contraindications to any of these agents:
iron sucrose (Venofer®), ferric gluconate (Ferrlecit®) and iron dextran (Infed®) ..... ☐ Yes ☐ No

If yes, what are the contraindications _____

Does the member have any of these conditions:

– Acute mountain sickness ☐ Yes ☐ No

– Anemia of inflammation ☐ Yes ☐ No

– Prophylactic use to improve function to non-anemic persons undergoing surgery for hip fracture ☐ Yes ☐ No

– Prophylactic use to prevent postoperative anemia in persons undergoing bariatric surgery ☐ Yes ☐ No

– Restless legs syndrome ☐ Yes ☐ No

By signing this form, the provider attests that the above information is accurate and documented in the medical record. Security Health Plan may, at its discretion, request medical records to make a final coverage determination.

_____ _____

Provider signature Date

Pre-service decisions: Initial review is received and a coverage determination is made within fourteen (14) calendar days of receipt of request. The member and/or provider are notified in writing of a denial decision within fourteen (14) calendar days of receipt of the request.

Urgent pre-service decisions: Initial review is received and a coverage determination is made within seventy-two (72) hours of receipt of request.

Mail or fax form to: Security Health Plan
Health Services Department
PO Box 8000
Marshfield, WI 54449-8000

Fax 715-221-6616

Marshfield Clinic providers route to:
Health Services Department
Routing location, SHP

If you have any questions, please contact Customer Service at 1-800-548-1224

