Member Name: _____ Member ID: _____ Member DOB: _____

Drug Name: _____ Strength: _____ Directions: _____

Physician Name: _____ Physician Phone #: _____ Specialty: _____

Physician Fax #: _____ Pharmacy Name: _____Pharmacy Phone: _____

Horizon NJ Health

Intravenous (IV) Iron Therapy – Medical Necessity Request

1. Can the member take oral iron instead? **Yes or No**
   a. If yes, please call the oral iron prescription into the member's pharmacy, then return form to HNJH.
   b. If no, what is the clinical reason why the member cannot take oral iron therapy?
   _____

2. What is the member's diagnosis?
   □ Anemia
   □ Other: _____

3. What is the anemia due to?
   □ Iron Deficiency
   □ Cancer/Chemotherapy
   □ Other: _____

4. Is the member receiving an erythropoietin (e.g., Procrit)? **Yes or No**

5. Does the member have Chronic Kidney Disease? **Yes or No**

6. Is the goal of IV iron therapy to avoid allogenic transfusion? **Yes or No**

Lab Values – Please specify units for all values and fax a copy of the lab results.

- Serum iron level: _____ Date Taken: _____
- Total Iron Binding Capacity: _____ Date Taken: _____
- Serum Ferritin: _____ Date Taken: _____
- Transferrin Saturation (TSAT): _____ Date Taken: _____
- Hemoglobin: _____ Date Taken: _____

**Please note, levels must be from within the past 60 days*

Physician office's signature*_____ Print Name_____

*** Form must be completed and signed by physician or licensed representative from the physician's office**