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**