Medica (formerly WellFirst Health)

Coverage of any drug intervention discussed in a Medica prior authorization guideline is subject to the limitations and exclusions outlined in the member's benefit certificate or policy and applicable state and/or federal laws.

☒ Commercial (Small & Large Group) ☒ ASO ☒ Exchange/ACA
☐ Medicare Advantage (MAPD)

Parenteral Iron Products MB2134

Covered Service: Yes

Prior Authorization Required: No, for preferred products (Venofer, INFeD, Ferrlecit, Feraheme)
Yes, for non-preferred products (Injectafer, Monoferric)

Additional Information: Venofer (iron sucrose), INFeD (iron dextran), Ferrlecit (sodium ferric gluconate complex), and Feraheme (ferumoxytol) are the preferred parenteral iron products.

Medicare Policy: Prior authorization is not required for Medicare Cost products (Dean Care Gold) and Medicare Supplement (Select) when this drug is provided by participating providers. Prior authorization is required if a member has Medicare primary and the plan secondary coverage. This policy is not applicable to our Medicare Replacement products.

Wisconsin Medicaid Policy Coverage of prescription drug benefits is administered by the Wisconsin Medicaid program. Coverage of medical drug benefits is administered by the Wisconsin Medicaid fee-for-service program. Medical drugs not paid on a fee-for-service basis by the Wisconsin Medicaid program are covered by the plan with no PA required.

Plan Approved Criteria

1.0 Injections of drugs that are administered at an excessive frequency or dose are not medically necessary. Frequency or dosing are considered excessive when services are performed more frequently or at a higher dose than listed in the FDA-approved package insert, listed in this document or generally accepted by peers and the reason for additional services is not justified by submitted documentation of clinical evidence. Route of administration of injectable drugs should follow the FDA-approved package insert.

NO PRIOR AUTHORIZATION REQUIRED FOR PREFERRED PRODUCTS

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(VENOFER, INFeD, FERRLECIT, FERAHEME)

Initial Criteria FOR NON-PREFERRED PRODUCTS (INJECTAFER, MONOFERRIC) (approved for three months, subject to formulary changes)

1.0 One of the following:

- 1.1 Submission of lab values (within 1 to 3 weeks following last dose) demonstrating treatment failure after at least 3 weeks of therapy to at least two of the four preferred agents; OR
- 1.2 History of intolerance, contraindication, or severe adverse event, to at least two of the four preferred IV therapies not previously tried and experienced treatment failure, and physician attests that in their clinical opinion, the same intolerance, contraindication, or severe adverse event would not be expected to occur

2.0 Member must have a diagnosis of an FDA approved indication

- 2.1 Injectafer, Monoferric

Continuation Criteria FOR NON-PREFERRED PRODUCTS (INJECTAFER, MONOFERRIC) (approved for three months, subject to formulary changes):

1.0 Submission of recent lab results (within 4 weeks) since the last treatment with a non-preferred product to demonstrate need for additional therapy

2.0 Diagnosis of an FDA approved indication

Comment(s):

1.0 Quantity limit includes: Maximum dose every 90 days

Product	Dosage series
INFeD (iron dextran)	1000mg once
Venofer (iron sucrose)	1000 mg
Ferrlecit (sodium ferric gluconate complex)	1000 mg
Feraheme (ferumoxytol)	1020 mg
Injectafer (ferric carboxymaltose)	(up to 1500 mg)

Monoferric (ferric derisomaltose)	1000mg once

2.0 *Coding specifications

2.1 *Codes and descriptors listed in this policy are provided for informational purposes only and may not be all inclusive or current. Listing of a code in this drug policy does not imply that the service described by the code is a covered or non-covered service. Benefit coverage for any service is determined by the member's policy of health coverage with the plan. Inclusion of a code in the table does not imply any right to reimbursement or guarantee claim payment. Other drug or medical policies may also apply.

2.1.1 NDC and HCPCS codes

Brand	How supplied (elemental iron)	HCPCS code
InFeD	2mL (100mg) single dose vial	J1750
Venofer	2.5mL (50mg), 5mL (100mg), and 10mL (200mg) single dose vials	J1756
Ferrlecit	5mL (62.5mg) single dose vial	J2916
Feraheme	17mL (510mg) single dose vial	Q0138 Q0139
Injectafer	2 mL (100mg), 15mL (750mg) and 20mL (1000mg) single dose vials	J1439
Monoferric	1mL (100mg), 5mL (500mg), and 10 mL (1000mg) single dose vials	J1437

3.0 **NOTE: The use of physician samples or manufacturer discounts does not guarantee later coverage under the provisions of the medical certificate and/or**

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pharmacy benefit. All criteria must be met in order to obtain coverage of the listed drug product.

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References:

1. INFeD [prescribing information]. Madison, NJ: Allergan USA, Inc.; April 2021.
2. Venofer [prescribing information]. Shirley, NY: American Regent, Inc; October 2020.
3. Ferrlecit [prescribing information]. Bridgewater, NJ: Sanofi-Aventis, LLC; December 2020.
4. Feraheme [prescribing information]. Waltham, MA: AMAG Pharmaceuticals, Inc; September 2020.
5. Injectafer [prescribing information]. Shirley, NY: American Regent, Inc; November 2021.

6. Monoferric [prescribing information]. Morristown, NJ: Pharmacosmos Therapeutics Inc.; November 2021.