Intravenous Iron

BENEFIT APPLICATION

Benefit determinations are based on the applicable contract language in effect at the time the services were rendered. Exclusions, limitations or exceptions may apply. Benefits may vary based on contract, and individual member benefits must be verified. Wellmark determines medical necessity only if the benefit exists and no contract exclusions are applicable. This medical policy may not apply to FEP. Benefits are determined by the Federal Employee Program.

DESCRIPTION

This policy informs prescribers of preferred products and provides an exception process for non-preferred products through prior authorization.

This program applies to the intravenous iron products specified in this policy. Coverage for a non-preferred product is provided based on clinical circumstances that would exclude the use of the preferred product and may be based on previous use of a product. The coverage review process will ascertain situations where a clinical exception can be made. This program applies to all members requesting treatment with the non-preferred product.

Note:
The preferred products are considered medically necessary and **do not require prior authorization.**

Table. Intravenous Iron Products

Medication	Generic Name
Preferred Products:	
Feraheme	ferumoxytol
Ferrlecit	sodium ferric gluconate
Infed	iron dextran
Venofer	iron sucrose
Targeted/Non-Preferred Products:	
Injectafer	ferric carboxymaltose

Monoferric	ferric derisomaltose

POLICY

*The preferred products Feraheme, Ferrlecit, Infed, and Venofer are considered medically necessary and **do not require prior authorization.**

EXCEPTION CRITERIA

Coverage for a non-preferred product is provided when ONE of the following criteria is met:

- The member has had a documented inadequate response, intolerable adverse event, or a contraindication to the preferred products
- The member is currently receiving therapy with a non-preferred product and is experiencing a positive therapeutic outcome.

Dosing and Administration
Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

PROCEDURES AND BILLING CODES

To report provider services, use appropriate CPT* codes, Alpha Numeric (HCPCS level 2) codes, Revenue codes, and/or ICD diagnostic codes.

- J1437 – injection, ferric derisomaltose (Monoferric), 10 mg
- J1439 – injection, ferric carboxymaltose (Injectafer), 1 mg
- J1750 – injection, iron dextran (Infed), 50 mg
- J1756 – injection, iron sucrose (Venofer), 1 mg
- J2916 – injection, sodium ferric gluconate complex (Ferrlecit), 12.5 mg
- Q0138 – injection, ferumoxytol (Feraheme), 1 mg (non-esrd)
- Q0139 – injection, ferumoxytol (Feraheme), 1 mg (for esrd on dialysis)

REFERENCES

Feraheme [package insert]. Waltham, MA: AMAG Pharmceuticals, Inc.; June 2022.

Ferrlecit [package insert]. Bridgewater, NJ: Sanofi-Aventis U.S. LLC; March 2022.

Infed [package insert]. Madison, NJ: Allergan USA, Inc.; April 2021.

Injectafer [package insert]. Shirley, NY: American Regent, Inc.; April 2021.

Monoferric [package insert]. Holbaek, Denmark: Pharmacosmos A/S; January 2020.

Venofer [package insert]. Shirley, NY: American Regent, Inc.; June 2022.

POLICY HISTORY

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