ALBERTA BLUE CROSS®

IRON (INTRAVENOUS)
SPECIAL AUTHORIZATION REQUEST FORM

Please complete all required sections to allow your request to be processed.

Patients may or may not meet eligibility requirements as established by Alberta government-sponsored drug programs.

PATIENT INFORMATION				COVERAGE TYPE
PATIENT LAST NAME	FIRST NAME		INITIAL	☐ Alberta Blue Cross ☐ Alberta Human Services ☐ Other
BIRTH DATE (YYYY-MM-DD)	ALBERTA PERSONAL HEALTH NUMBER			
STREET ADDRESS	CITY	PROV	POSTAL CODE	ID/CLIENT/COVERAGE NUMBER

PRESCRIBER INFORMATION			
PRESCRIBER LAST NAME	FIRST NAME	INITIAL	PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION ☐ CPSA ☐ ACO REGISTRATION NUMBER ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other
STREET ADDRESS			PHONE / FAX
CITY, PROVINCE			
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED

Please provide the following information for NEW requests

Product requested ☐ Ferric derisomaltose (e.g. Monoferric)

Diagnosis ☐ Iron deficiency anemia ☐ Other (specify) _____

Previous therapy (check all that apply)

☐ Oral iron therapy has been used → please complete a) and b)

a) Specify the formulation(s) used _____

b) Provide the patient's response

☐ Intolerance: Gastrointestinal side-effects → please indicate the measures taken to relieve the side-effects

- ☐ taking oral iron with small amounts of food
- ☐ utilizing alternate day dosing regimen of oral iron
- ☐ oral iron has been titrated up from low-dose

☐ Inadequate response: Hemoglobin (Hb) continues to decline (< 90g/L) → provide current Hb level (g/L) _____ date _____

☐ Inadequate response: Hb increased less than 10 g/L after 3 months of therapy → please provide Hb levels

Pre-treatment Hb level (g/L) _____ date _____ AND Current Hb level (g/L) _____ date _____

☐ Other (specify) _____

☐ Oral iron therapy has NOT been used → please provide reason

☐ Oral iron therapy is contraindicated → indicate if any of the following apply or otherwise specify

- ☐ Patient has clinical malabsorption
- ☐ Patient has chronic blood loss, in which the pace of iron loss exceed ability to replete from oral iron intake
- ☐ Patient has a time-limited condition (i.e. perioperative) where oral iron will not provide adequate Hb levels
- ☐ Other (specify) _____

☐ Other reason oral iron cannot be used (specify) _____

Please provide the following information for RENEWAL requests

1) Indicate the patient's response to intravenous iron therapy _____

2) The patient's underlying cause of iron deficiency anemia cannot be resolved and intravenous iron is required to maintain normal hemoglobin ☐ Yes ☐ No

Additional information relating to request

PRESCRIBER'S SIGNATURE	DATE	Please forward this request to
		Alberta Blue Cross, Clinical Drug Services **10009 108 Street NW, Edmonton, Alberta T5J 3C5** **FAX**: **780-498-8384** in Edmonton • **1-877-828-4106** toll free all other areas

ONCE YOUR REQUEST HAS SUCCESSFULLY TRANSMITTED, PLEASE DO NOT MAIL OR RE-FAX YOUR REQUEST

ALBERTA BLUE CROSS®

IRON (INTRAVENOUS)
SPECIAL AUTHORIZATION CRITERIA

Patients may or may not meet eligibility requirements as established by Alberta government sponsored drug programs.

Criteria for coverage

FERRIC DERISOMALTOSE (e.g. Monoferric) special authorization criteria

"For the treatment of iron deficiency anemia (IDA) in adult patients who have intolerance OR have an inadequate response to a trial of oral iron therapy, OR in whom oral iron therapy is contraindicated.

"Intolerance" is defined as the persistence of gastrointestinal side-effects despite having tried:
-an adequate trial of at least two different formulations of oral iron (e.g. iron salts, polysaccharide iron, heme iron), or
-taking oral iron with small amounts of food, or
-utilizing alternate day dosing regimen of oral iron, or
-oral iron has been titrated up from low-dose.

"Inadequate response" is defined as one or more of the following:
-Hemoglobin (Hb) continues to decline while on oral iron therapy (Hb <90 g/L), or
-Hb increases less than 10 g/L after three months of oral iron therapy.

Contraindications to oral iron therapy may include the following:
-Patients have clinical malabsorption (e.g. history of bariatric surgery, clinically active Inflammatory Bowel Disease (IBD), Celiac disease, Chronic Kidney Disease, short bowel syndrome), or
-Patients have chronic blood loss, in which the pace of iron loss exceed ability to replete from oral iron intake, or
-Patients have time-limited conditions (i.e. perioperative) where oral iron will not provide adequate Hb levels.

This Product must be administered in a setting where appropriate monitoring and management of hypersensitivity reactions can be provided.

Special authorization may be granted for 12 months.
Renewal requests may be considered if intravenous iron is required to maintain normal hemoglobin in patients for whom the underlying cause of iron deficiency anemia cannot be resolved (e.g. ongoing blood losses)."

ABC 60085 (2023/04)