Intravenous Iron Replacement Therapy (Feraheme®, Injectafer®, & Monoferric®) (for Indiana Only)

Policy Number: CSIND0088.06
Effective Date: March 1, 2025

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Related Policies
None

Application

This Medical Benefit Drug Policy only applies to the state of Indiana.

Coverage Rationale

This policy refers to the following intravenous iron replacements:
- Feraheme® (ferumoxytol)
- Injectafer® (ferric carboxymaltose)
- Monoferric® (ferric derisomaltose)

The following intravenous iron replacements are not subject to the coverage criteria in this section:
- Ferrlecit (sodium ferric gluconate complex)
- Infed® (iron dextran)
- Venofer® (iron sucrose)

Feraheme (ferumoxytol), Injectafer (ferric carboxymaltose), and Monoferric (ferric derisomaltose) are proven and medically necessary for the treatment of certain conditions outlined within the InterQual® criteria. For medical necessity clinical coverage criteria, refer to the current InterQual® guideline:
- **Feraheme®**: CP: Specialty Rx Non-Oncology, Ferumoxytol (Feraheme)
- **Injectafer®**: CP: Specialty Rx Non-Oncology, Ferric carboxymaltose (Injectafer)
- **Monoferric®**: CP: Specialty Rx Non-Oncology, Ferric derisomaltose (Monoferric)

Click here to view the InterQual® criteria.

Applicable Codes

The following list(s) of procedure codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by federal, state, or contractual requirements and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

HCPCS Code	Description
J1437	Injection, ferric derisomaltose, 10 mg
J1439	Injection, ferric carboxymaltose, 1 mg
Q0138	Injection, ferumoxytol, for treatment of iron deficiency anemia, 1 mg (non-ESRD use)
Q0139	Injection, ferumoxytol, for treatment of iron deficiency anemia, 1 mg (for ESRD on dialysis)

Policy History/Revision Information

Date	Summary of Changes
03/01/2025	• Routine review, no content changes • Archived previous policy version CSIND0088.05

Instructions for Use

This Medical Benefit Drug Policy provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the federal, state, or contractual requirements for benefit plan coverage must be referenced as the terms of the federal, state, or contractual requirements for benefit plan coverage may differ from the standard benefit plan. In the event of a conflict, the federal, state, or contractual requirements for benefit plan coverage govern. Before using this policy, please check the federal, state, or contractual requirements for benefit plan coverage. UnitedHealthcare reserves the right to modify its Policies and Guidelines as necessary. This Medical Benefit Drug Policy is provided for informational purposes. It does not constitute medical advice.

UnitedHealthcare may also use tools developed by third parties, such as the InterQual® criteria, to assist us in administering health benefits. The UnitedHealthcare Medical Benefit Drug Policies are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.