







FAX Completed Form To 1.833.404.2392

Pharmacy Help Desk 1.800.460.8988

Prescriber Help Desk 1.833.587.2012

Request for Prior Authorization Deferasirox

(PLEASE PRINT - ACCURACY IS IMPORTANT)

IA Medicaid Member ID #	Patient name		DOB	
Patient address				
Provider NPI	Prescriber name		Phone	
	Frescriber flame		FIIOHE	
Prescriber address			Fax	
Pharmacy name	Address		Phone	
Prescriber must complete all informa	tion above. It must be legible, corre	ect, and complete or f	orm will be returned.	
Pharmacy NPI	Pharmacy fax	NDC		
Prior authorization is required fo	r deferacion Peguests will onl	y be considered fo	r FDA approved dosing	
Payment will be considered under the following conditions: 1) Patient does not have a serum creatinine greater than 2 times the age-appropriate upper limit of normal or creatinine clearance < 40mL/min; and 2) Patient does not have a poor performance status; and 3) Patient does not have a high-risk myelodysplastic syndrome; and 4) Patient does not have advanced malignancies; and 5) Patient does not have a platelet count < 50 x 10 ⁹ /L. Preferred Non-Preferred				
Strength	Dosage Instructions	Quantity	Days Supply	
5 5 5			,	
Patient has a diagnosis of iron overload related to anemia: Yes (attach documentation) No (provide diagnosis): Indicate member's current deferasirox treatment status: Initial Continuation				
Patient's current weight in kg: Date obtained:				
Serum Creatinine greater than ☐ Yes ☐ No Date obta	•	upper limit of no	rmal?	
Creatinine Clearance: Date obtained:		obtained:	<u>.</u>	
Platelet Count:		Date obtained:		
Serum Ferritin:		Date obtained:		
	(attac	ch labs dated withir	n 30 days of request)	
Does patient have poor performance status? \square Yes \square N		☐ Yes ☐ No		
Does patient have high-risk myelodysplastic syndrome? ☐ Yes ☐ No				
Does patient have advanced r	nalignancies?	☐ Yes ☐ No		

1 of 2 Rev. 10/19





Request for Prior Authorization - Continued DEFERASIROX

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☐ Transfusional Iron Overload (in addition to above):					
Initiation of Therapy: 1) Patient is 2 years of age or older; and 2) Patient has documentation of iron overload related to anemia (attach documentation); and 3) Patient has documentation of a recent history of frequent blood transfusions that has resulted in chronic iron overload; and 4) Serum ferritin is consistently > 1000 mcg/L (attach lab results dated within past month); and 5) Starting dose does not exceed: Exjade- 20mg/kg/day or Jadenu- 14mg/kg/day. Calculate dose to the nearest whole tablet. 6) Initial authorizations will be considered for up to 3 months. Continuation of therapy: 1) Serum ferritin has been measured within 30 days of continuation therapy request (attach lab results); and 2) Ferritin levels are > 500mcg/L and 3) Dose does not exceed: Exjade- 40mg/kg/day or Jadenu- 28mg/kg/day.					
Initial Requests:					
Patient has a recent history of frequent blood transfusions resulting in chronic iron overload?					
Yes (provide recent transfusion dates)	No				
Serum ferritin consistently > 1000 mcg/L: ☐ Yes ☐ No					
□ Non-Transfusional Iron Overload (in addition to above)					
Initiation of therapy: 1) Patient is 10 years of age or older; and 2) Patient has documentation of iron overload related to anemia (attach documentation); and 3) Serum ferritin and liver iron concentration (LIC) has been measured within 30 days of initiation (attach lab results); and 4) Serum ferritin levels are > 300mcg/L . 5) LIC are > 5mg Fe/g dw; and 6) Dose does not exceed: Exjade- 10mg/kg/day (if LIC is $\leq 15 \text{mg}$ Fe/g dw) or 20mg/kg/day (if LIC is > 15mg Fe/g dw) or 14mg/kg/day (if LIC is > 15mg Fe/g dw). 7) Initial authorizations will be considered for up to 6 months. Continuation of Therapy: 1) Serum ferritin and LIC have been measured within 30 days of continuation therapy request; and 2) Serum ferritin levels are $\geq 300 \text{mcg/L}$; and 3) LIC is $\geq 3 \text{mg}$ Fe/g dw; and 4) Dose does not exceed: Exjade- 10mg/kg/day (if LIC is 3 to 10mg/kg/day (if LIC is $10 mg/kg/d$					
Initial & Renewal Requests:					
IC: Date obtained: (attach labs dated within 30 days of request)					
Attach lab results and other documentation as necessary.					
Prescriber signature (Must match prescriber listed above.)	Date of submission				

IMPORTANT NOTE: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.

2 of 2 Rev. 10/19