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Exjade (Deferasirox) Prior Authorization of Benefits Form

CONTAINS CONFIDENTIAL PATIENT INFORMATION
Complete form in its entirety and fax to: Prior Authorization of Benefits Center at 1-844-512-9004 or Provider Help Desk 1-800-454-3730

1. Patient information	**2. Physician information**
Patient name: _____	Prescribing physician: _____
Patient ID #: _____	Physician address: _____
Patient DOB: _____	Physician phone #: _____
Date of Rx: _____	Physician fax #: _____
Patient phone #: _____	Physician specialty: _____
Patient email address: _____	Physician DEA: _____
	Physician NPI #: _____
	Physician email address: _____

3. Medication	**4. Strength**	**5. Directions**	**6. Quantity per 30 days**
_____	_____	_____	Specify: _____
7. Diagnosis: _____			

8. Approval criteria: (Check all boxes that apply. Note: Any areas not filled out are considered not applicable to your patient and may affect the outcome of this request.)

Prior authorization is required for deferasirox. Requests will only be considered for 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 109/L.

Preferred	**Non-Preferred**	
□ Exjade	□ Deferasirox	□ Jadenu

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 2 times the age-appropriate upper limit of normal?
□ Yes □ No Date obtained: _____
Creatinine Clearance: _____ Date obtained: _____
Platelet Count: _____ Date obtained: _____
Serum Ferritin: _____Date obtained: _____
(attach labs dated within 30 days of request)

Does patient have poor performance status? □ Yes □ No
Does patient have high-risk myelodysplastic syndrome? □ Yes □ No
Does patient have advanced malignancies? □ Yes □ No
□ **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 ≤ 15mg Fe/g dw) or 20mg/kg/day (if LIC is > 15mg Fe/g dw) or Jadenu- 7mg/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 ≥ 300mcg/L; and 3) LIC is ≥ 3mg Fe/g dw; and 4) Dose does not exceed: Exjade- 10mg/kg/day (if LIC is 3 to 7mg Fe/g dw) or 20mg/kg/day (if LIC is > 7mg Fe/g dw) or Jadenu- 7mg/kg/day (if LIC is 3 to 7mg Fe/g dw) or 14mg/kg/day (if LIC is > 7mg Fe/g dw).

Initial & Renewal Requests:
LIC: _____ Date obtained: _____ (attach labs dated within 30 days of request)

Attach lab results and other documentation as necessary.

9. Physician signature

_____	_____
Prescriber or authorized signature	Date
Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations and exclusions. The submitting provider certifies that the information provided is true, accurate and complete and the requested services are medically indicated and necessary to the health of the patient. Note: Payment is subject to member eligibility. Authorization does not guarantee payment.	
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