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CONTAINS CONFIDENTIAL PATIENT INFORMATION

Jadenu (deferaxirox)

Prior Authorization of Benefits (PAB) Form

Complete form in its entirety and fax to:
Prior Authorization of Benefits Center at 1-844-512-9004
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**
Jadenu (deferasirox)	____________	______________________	Specify: ______________

7. DIAGNOSIS: ____

8. APPROVAL CRITERIA: CHECK ALL BOXES THAT APPLY
NOTE: Any areas not filled out are considered not applicable to your patient & MAY AFFECT THE OUTCOME of this request.

Patient's current weight in kg:_ Date obtained: ________

Creatinine Clearance:_________________Date obtained: ______________

Platelet Count:________________________Date obtained: ______________

Serum Ferritin:________________________ Date obtained: ____________
(attach labs dated within 30 days of request)

☐ Yes ☐ No Documentation* has been provided with this request showing a previous trial and therapy failure with preferred agent Exjade at the maximally tolerated dose

☐ Yes ☐ No Patient has a serum creatinine greater than 2 times the age-appropriate upper limit of normal or creatinine clearance less than 40mL/min

☐ Yes ☐ No Patient has poor performance status

☐ Yes ☐ No Patient has high-risk myelodysplastic syndrome

☐ Yes ☐ No Patient advanced malignancies

☐ Yes ☐ No Patient has a platelet count less than 50 x 10^9/L

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PATIENT NAME:____**PATIENT ID #:** __________________________

Transfusion Iron Overload – Initiation of Therapy

☐ Yes	☐ No	Documentation* has been provided with this request showing iron overload related to anemia
☐ Yes	☐ No	Documentation* has been provided with this request of a recent history of frequent blood transfusions that have resulted in chronic iron overload
☐ Yes	☐ No	Serum ferritin is consistently greater than 1000 mcg/L (lab results dated within the past month must be attached)
☐ Yes	☐ No	Starting dose exceeds 14mg/kg/day
☐ Yes	☐ No	Patient is 2 years of age or older

Transfusion Iron Overload – Continuation of Therapy

☐ Yes	☐ No	Serum ferritin is greater than 500 mcg/L (lab results dated within the past month must be attached)
☐ Yes	☐ No	Dose exceeds 28mg/kg/day

Non-Transfusion Iron Overload – Initiation of Therapy

☐ Yes	☐ No	Documentation* has been provided with this request showing iron overload related to anemia
☐ Yes	☐ No	Serum ferritin and liver iron concentration (LIC) have been measured within 30 days of this request (lab results must be attached)
☐ Yes	☐ No	Serum ferritin levels is greater than 300mcg/L
☐ Yes	☐ No	LIC is greater than 5mg Fe/g dw
☐ Yes	☐ No	Dosing exceeds 7mg/kg/day (if LIC is less than 15mg Fe/g dw) or 14mg/kg/day (if LIC is greater than 15mg Fe/g dw)
☐ Yes	☐ No	Patient is 10 years of age or older

Non-Transfusion Iron Overload – Continuation of Therapy

☐ Yes	☐ No	Serum ferritin and liver iron concentration (LIC) have been measured within 30 days of this request
☐ Yes	☐ No	Serum ferritin levels is greater than or equal to 300mcg/L
☐ Yes	☐ No	LIC is greater than or equal to 3mg Fe/g dw
☐ Yes	☐ No	Dosing exceeds 7mg/kg/day (if LIC is 3 to 7 mg Fe/g dw) or 14mg/kg/day (if LIC is greater than 7mg Fe/g dw

***Documentation may include, but is not limited to, chart notes, prescription claims records, prescription receipts, and laboratory data.**

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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