Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

DEFERASIROX - (Exjade® and Jadenu®)

Phone: 215-991-4300 Fax back to: 866-240-3712

Health Partners Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**	
HPP Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Address:	NPI:	Promise ID:
City, State ZIP:	*Prescriber PA PROMISe ID:*	
Patient Primary Phone:	Address:	
Line of Business: □ Medicaid □ CHIP	City, State ZIP: Specialty/facility name (if applicable):	

□ Expedited/Urgent

Drug Name:
Strength:
Days Supply:
Number of Refills:
Directions / SIG:

HPP's maximum approval time is 12 months but may be less depending on the drug.

Please attach any pertinent medical history including labs and information for this member that may support approval.
Please answer the following questions and sign.

Q1. Does the patient have a diagnosis of transfusion iron overload, and have transfusion of greater than or equal to 100 mL/kg of packed red blood cells [greater than or equal to 20 units for a 40 kg individual] and serum ferritin consistently >1000 mcg/L?

☐ Yes ☐ No

Q2. Is the patient 2 years of age or older?

☐ Yes ☐ No

Q3. Does the patient have a diagnosis of chronic iron overload with non-transfusion dependent thalassemia syndromes with a liver iron (Fe) concentration (LIC) of at least 5 mg Fe per gram of dry weight (mg Fe/g dw) and a serum ferritin greater than 300 mcg/L?

☐ Yes ☐ No

Q4. Is the patient 10 years of age or older?

☐ Yes ☐ No

Q5. For transfusional iron overload, have the following lab results been attached? a. Serum ferritin level b. Serum creatinine and determine the creatinine clearance c. Serum transaminases and bilirubin d. Baseline auditory and ophthalmic examinations

☐ Yes ☐ No

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Patient Name:	**Prescriber Name:**

Q6. For chronic iron overload with non-transfusion dependent thalassemia syndromes, have the following lab results been attached? a. Serum ferritin level on at least 2 measurements one month apart b. Serum creatinine and determine the creatinine clearance c. Serum transaminases and bilirubin d. Baseline auditory and ophthalmic examinations e. LIC by liver biopsy or by an FDA-cleared or approved method for identifying patients for treatment with deferasirox therapy

☐ Yes ☐ No

Q7. Requested Duration:

☐ 2 Months

Q8. Additional Information:

Prescriber Signature

Date

Updated 2018