



**HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM**

Health Partners Plans

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:	<i>Prescriber PA PROMISe ID:</i>
Patient Primary Phone:	Address: _____
Line of Business: <input type="checkbox"/> Medicaid	City, State ZIP: _____
<input type="checkbox"/> CHIP	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

This telecopy transmission contains confidential information belonging to the sender that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reference to the contents of this document is strictly prohibited. If you have received this telecopy in error, please notify the sender immediately to arrange for the return of this document



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:

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