PA Request Criteria

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207023

This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to CVS/Caremark at . Please contact CVS/Caremark at 1-888-413-2723 with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of the medication.

Patient Name: _____ **Date:** 5/13/2025
Patient ID: _____ **Patient Date Of Birth:** _____
Patient Group No: **Patient Phone:** **Physician Name:**
_____ **NPI#:** _____ **Specialty:**
_____ **Physician Office Telephone:**
Physician Office Address: _____
_
Drug Name (specify drug) _____
Quantity: _____ **Frequency:** _____ **Strength:** _____
Route of Administration: _____ **Expected Length of Therapy:** _____
Diagnosis: _____ **ICD Code:** _____
Comments: _____
_____
_____

Please check the appropriate answer for each applicable question.

1. Is the patient currently receiving treatment with the requested medication? **Y** ☐ **N** ☐

2. What is the diagnosis?
   - Chronic iron overload due to blood transfusions (transfusional iron overload) (If checked, go to 3) ☐
   - Chronic iron overload in a patient with non-transfusion-dependent thalassemia syndromes (If checked, go to 5) ☐
   - Hereditary hemochromatosis (If checked, go to 7) ☐
   - Other, please specify (If checked, no further questions) ☐

   _____

3. Is the patient experiencing benefit from therapy as evidenced by a decrease in serum ferritin levels as compared to pretreatment baseline? ACTION REQUIRED: If Yes, attach supporting laboratory report or chart notes with current serum ferritin level. ACTION REQUIRED: Submit supporting documentation **Y** ☐ **N** ☐

4. Is the patient's serum ferritin level consistently below 500 mcg/L? **Y** ☐ **N** ☐

5. Is the patient experiencing benefit from therapy as evidenced by a decrease in serum ferritin levels as compared to pretreatment baseline? ACTION REQUIRED: If Yes, attach supporting laboratory report or chart notes with current serum ferritin level. ACTION REQUIRED: Submit supporting documentation **Y** ☐ **N** ☐

6. Is the patient's serum ferritin level consistently below 300 mcg/L? **Y** ☐ **N** ☐

7. Is the patient experiencing benefit from therapy as evidenced by a decrease in serum ferritin levels as compared to pretreatment baseline? **Y** ☐ **N** ☐

8. What is the diagnosis?
   - Chronic iron overload due to blood transfusions (transfusional iron overload) (If ☐ checked, go to 9)
   - Chronic iron overload in a patient with non-transfusion-dependent thalassemia ☐ syndromes (If checked, go to 13)
   - Hereditary hemochromatosis (If checked, go to 20) ☐
   - Other, please specify (If checked, no further questions) ☐

9.	Is the patient's pretreatment serum ferritin level consistently greater than 1000 mcg/L? ACTION REQUIRED: If Yes, attach supporting laboratory report or chart notes with pretreatment serum ferritin level. ACTION REQUIRED: Submit supporting documentation	**Y** ☐	**N** ☐
10.	Which product is being requested?		
	deferasirox tablets for suspension or Exjade (If checked, go to 11)	☐	
	deferasirox tablets or Jadenu (If checked, go to 12)	☐	
11.	Will the dose of deferasirox tablets for suspension or Exjade exceed 40 mg/kg per day?	**Y** ☐	**N** ☐
12.	Will the dose of deferasirox tablets or Jadenu exceed 28 mg/kg per day?	**Y** ☐	**N** ☐
13.	Is the patient's pretreatment serum ferritin level greater than or equal to 800 mcg/L? ACTION REQUIRED: Attach supporting laboratory report or chart notes with pretreatment serum ferritin level. ACTION REQUIRED: Submit supporting documentation	**Y** ☐	**N** ☐
14.	Is the patient's pretreatment serum ferritin level greater than 300 mcg/L to less than 800 mcg/L? ACTION REQUIRED: Attach supporting laboratory report or chart notes with pretreatment serum ferritin level. ACTION REQUIRED: Submit supporting documentation	**Y** ☐	**N** ☐
15.	Does the patient have clinical or laboratory measures indicative of iron overload (e.g., liver disease, renal disease)?	**Y** ☐	**N** ☐
16.	Is the patient's pretreatment liver iron concentration (LIC) at least 5 milligrams of iron per gram of liver dry weight (mg Fe/g dw)? ACTION REQUIRED: Attach supporting laboratory report or chart notes with pretreatment liver iron concentration. ACTION REQUIRED: Submit supporting documentation	**Y** ☐	**N** ☐
17.	Which product is being requested?		
	deferasirox tablets for suspension or Exjade (If checked, go to 18)	☐	
	deferasirox tablets or Jadenu (If checked, go to 19)	☐	
18.	Will the dose of deferasirox tablets for suspension or Exjade exceed 20 mg/kg per day?	**Y** ☐	**N** ☐
19.	Will the dose of deferasirox tablets or Jadenu exceed 14 mg/kg per day?	**Y** ☐	**N** ☐
20.	Has the patient had an unsatisfactory response to phlebotomy?	**Y** ☐	**N** ☐
21.	Is phlebotomy not an option for the patient (e.g., poor venous access, poor candidate due to underlying medical conditions)?	**Y** ☐	**N** ☐

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

_____

Prescriber (Or Authorized) Signature and Date