Member Name: {{MEMFIRST}} {{MEMLAST}} **DOB:** {{MEMBERDOB}} **PA Number:** {{PANUMBER}}

{{PANUMCODE}}

{{DISPLAY_PAGNAME}}
{{PACDESCRIPTION}}

This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to {{COMPANY_NAME}} at {{CLIENT_PAG_FAX}}. Please contact {{COMPANY_NAME}} at {{CLIENT_PAG_PHONE}} with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of {{DRUGNAME}}.

Patient's Name: {{MEMFIRST}} {{MEMLAST}} **Date**: {{TODAY}}
Patient's ID: {{MEMBERID}} **Patient's Date of Birth:** {{MEMBERDOB}}
Physician's Name: {{PHYFIRST}} {{PHYLAST}} **Patient Phone:** <<MEMPHONE>>
Specialty: _____ **NPI#:** _____
Physician Office Telephone: {{PHYSICIANPHONE}} **Physician Office Fax:** {{PHYSICIANFAX}}
Physician Office Address: <<PHYADDRESS1>> <<PHYADDRESS2>> <<PHYCITY>>, <<PHYSTATE>> <<PHYZIP>>
Drug Name: {{DRUGNAME}}

Quantity: _____ **Frequency:** _____ **Strength:** _____
Route of Administration: _____ **Expected Length of Therapy:** _____
Diagnosis: <<DIAGNOSIS>> **ICD Code**: <<ICD9>>

1. Which product is being requested?
   ❑ deferasirox tablets for suspension or Exjade ❑ deferasirox tablets or Jadenu

2. What is the diagnosis?
   ❑ Chronic iron overload due to blood transfusions (transfusional iron overload)
   ❑ Chronic iron overload due to a non-transfusion-dependent thalassemia syndrome
   ❑ Hereditary hemochromatosis
   ❑ Other _____

3. Is the patient currently receiving treatment with the requested medication? ❑ Yes ❑ No

Complete the following section based on patient's diagnosis, if applicable.

Section A: Chronic Iron Overload Due to Blood Transfusions (Transfusional Iron Overload)
Continuation

1. 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***. ❑ Yes ❑ No

2. Is the patient's serum ferritin level consistently below 500 mcg/L? ❑ Yes ❑ No *No further questions.*

Initial

3. 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.*** ❑ Yes ❑ No

Section B:Chronic Iron Overload Due to a Non-Transfusion-Dependent Thalassemia Syndrome
Continuation

1. 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.*** ❑ Yes ❑ No

2. Is the patient's serum ferritin level consistently below 300 mcg/L? ❑ Yes ❑ No *No further questions.*

Initial

3. Is the patient's pretreatment serum ferritin level greater than 800 mcg/L? ***ACTION REQUIRED: Attach supporting laboratory report or chart notes with pretreatment serum ferritin level.*** ❑ Yes ❑ No

4. 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.*** ❑ Yes ❑ No

5. Does the patient have clinical or laboratory measures indicative of iron overload (e.g., liver disease, renal disease)? ❑ Yes ❑ No

6. 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.*** ❑ Yes ❑ No

Section C: Hereditary Hemochromatosis

Continuation

1. Is the patient experiencing benefit from therapy as evidenced by a decrease in serum ferritin levels as compared to pretreatment baseline? ❑ Yes ❑ No *No further questions.*

Initial

2. Has the patient had an unsatisfactory response to phlebotomy? *If Yes, no further questions.* ❑ Yes ❑ No

3. Is phlebotomy not an option for the patient (e.g., poor venous access, poor candidate due to underlying medical conditions)? ❑ Yes ❑ No

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