BlueCross BlueShield Federal Employee Program®

EXJADE / JADENU
PRIOR APPROVAL REQUEST

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		

PHYSICIAN COMPLETES

For Standard Option patients GENERIC Exjade (deferasirox) and GENERIC Jadenu (deferasirox) are preferred products. Standard Option patients who switch to a preferred product will be eligible for 2 copays at no cost in the benefit year.

NOTE: Form must be completed in its **entirety** for processing

Please select medication: ❑ **Exjade (deferasirox)** ❑ **Jadenu (deferasirox)**

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

Is this request for brand or generic? ❑Brand ❑Generic

BRAND Exjade or BRAND Jadenu Request (Standard Option Patient): Would you like to switch the patient to the preferred product, deferasirox (**generic** Exjade or **generic** Jadenu)? ❑Yes, switch to the **generic** deferasirox ❑No, do not switch*

If NO**, does the patient have an intolerance or contraindication or have they had an inadequate treatment response to the **generic** deferasirox? ***Please select answer below:

❑**Yes**, specify result(s): _____

❑**No**: Is there a clinical reason for not trying the **generic** deferasirox? ❑Yes* ❑No

***If YES**, please specify: _____

1. What is the patient's diagnosis?
   - ❑Chronic iron overload due to blood transfusions
   - ❑Non-Transfusion-Dependent Thalassemia (NTDT)
     a. Does the patient have a liver iron concentration (LIC) of at least 5 milligrams of iron per gram of dry liver tissue weight? ❑Yes ❑No
   - ❑Other diagnosis ***(please specify)***: _____
2. What is the patient's serum ferritin level? _____ mcg/L
3. Does the patient have a platelet count greater than 50,000 per microliter? ❑Yes ❑No
4. Does the patient have high-risk myelodysplastic syndromes (MDS)? ❑Yes ❑No
5. Does the patient have advanced malignancies? ❑Yes ❑No
6. Does the patient have a severe hepatic impairment (Child-Pugh C)? ❑Yes ❑No
7. Does the patient have a serum creatinine greater than 2 times the age-appropriate upper limit of normal? ❑Yes ❑No
8. Does the patient have a creatinine clearance less than 40 mL/min? ❑Yes ❑No
9. Will this medication be used in combination with another *iron chelating agent? ❑Yes* ❑No

   ***If YES**, specify medication(s): _____

   ****Iron Chelating Agents: Exjade (deferasirox), Ferriprox (deferiprone), Jadenu (deferasirox)***
10. Has the patient been on this medication continuously for the last **6 months**, excluding samples? ***Select answer below:***

    ❑**NO** – this is **INITIATION** of therapy, please answer the following question(s):
    a. Will the patient's baseline transaminases (AST and ALT) and bilirubin be obtained prior to initiation of therapy and every two weeks during the first month? ❑Yes* ❑No

    ***If YES**, will the patient's transaminases (AST/ALT) and bilirubin be monitored at least monthly going forward? ❑Yes ❑No

    ❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following question:
    a. Will the patient's transaminases (AST and ALT) and bilirubin be monitored at least monthly going forward? ❑Yes ❑No

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Message:

Attached is a Prior Authorization request form.

For your convenience, there are 3 ways to complete a Prior Authorization request:

Electronically Online (ePA) Results in 2-3 **minutes** **FASTEST AND EASIEST**	Now you can get responses to drug Prior Authorization requests **securely** online. **Online** submissions may receive **instant** responses and do not require faxing or phone calls. Requests can be made 24 hours a day, 7 days a week. For more information on electronic prior authorization (ePA) and to register, go to **Caremark.com/ePA.**
Phone (4-5 **minutes** for response)	The FEP Clinical Call Center can be reached at **(877)-727-3784** between the hours of 7AM-9PM Eastern Time. A live representative will assist with the Prior Authorization, asking for the same information contained on the attached form. Please review the form and have your answers ready for faster service. The process over the phone takes on average between 4 and 5 minutes.
Fax (3-5 **days** for response)	Fax the attached form to **(877)-378-4727**. Requests sent via fax will be processed and responded to within 5 business days. The form must be filled out completely, if there is any missing information the Prior Authorization request cannot be processed. ***Please only fax the completed form once as duplicate submissions may delay processing times.***