

Exjade[®] & Jadenu[®] Prior Authorization Request Form (Page 1 of 2)

Member Information (required)			Provider Information (required)				
Member Name:			Provider Name:				
Insurance ID#:			NPI#: Specialty:				
Date of Birth:			Office Phone:				
Street Address:			Office Fax:				
City:	State:	Zip:	Office Street Address:				
Phone:			City:	State:		Zip:	
	Ν	ledication Info	rmation (required)				
Medication Name:			Strength:	Dosage		orm:	
Check if requesting brand			Directions for Use:				
Check if request is for continuation of therapy							
Clinical Information (required)							
Select the diagnosis below: Chronic iron overload due to blood transfusions (transfusional hemosiderosis) Chronic iron overload due to non-transfusion-dependent thalassemia (NTDT) Myelodysplastic syndrome (MDS) Other diagnosis: ICD-10 Code(s): For chronic iron overload due to blood transfusions (transfusional hemosiderosis), answer the following: Does the patient have a baseline ferritin level more than 1,000 mcg/L? Yes D No Has the patient required a transfusion of at least 100 mL/kg packed red blood cells? Yes D No Reauthorization: Has the patient experienced a reduction, from baseline, in serum ferritin level or liver iron concentration (LIC)? Yes D No							
For chronic iron overload due to non-transfusion-dependent thalassemia (NTDT), answer the following: Does the patient have a liver iron concentration (LIC) of 5 milligrams iron per gram of liver dry weight (mg Fe/g dw) or higher? □ Yes □ No Does the patient have a baseline ferritin level more than 300 mcg/L? □ Yes □ No Reauthorization: Does the patient have a LIC of 3 mg Fe/g dw or higher? □ Yes □ No Has the patient experienced a reduction, from baseline, in serum ferritin level or liver iron concentration (LIC)? □ Yes □ No Is the patient have low or intermediate-1 disease? □ Yes □ No Has the patient a potential transplant patient? □ Yes □ No Has the patient received more than 20 red blood cell transfusions? □ Yes □ No Reauthorization: Has the patient experienced a reduction, from baseline, in serum ferritin level or liver iron concentration (LIC)? □ Yes □ No Has the patient a potential transplant patient? □ Yes □ No Has the patient received more than 20 red blood cell transfusions? □ Yes □ No Reauthorization: Has the patient experienced a reduction, from baseline, in serum ferritin level or liver iron concentration (LIC)? □ Yes □ No							

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1230 US Highway 11 Gouverneur, NY 13642 Phone: 1-877-635-9545

Prior Authorization Fax: 1-844-712-8129

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Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician fe els is important to this review?

Please note:	This request may be denied unless all required information is received.			
	Please fax this form to 1-844-712-8129 to initiate a prior authorization review for the member and medication above.			
	Please note: plan benefits may limit or exclude coverage of specific medications including those requested on this form.			

I certify, to the best of my knowledge, the statements and information provided on this form are factual and correct.

Provider/Representative (and Title): _____

Date:

PROACT INTERNAL USE ONLY:

Clinical Review Decision

A	Approved, through							
D	Denied (documentation attached, if necessary)							
Tracking:								
1 st Attempt		2 nd Attempt		Letter Mailed:				

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