1230 US Highway 11
Gouverneur, NY 13642
Phone: 1-877-635-9545
Prior Authorization Fax: 1-844-712-8129

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:

Medication Information (required)		
Medication Name:	Strength:	Dosage Form:
❑ 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** ❑ **No**
Has the patient required a transfusion of at least 100 mL/kg packed red blood cells? ❑ **Yes** ❑ **No**

Reauthorization:

Has the patient experienced a reduction, from baseline, in serum ferritin level or liver iron concentration (LIC)? ❑ **Yes** ❑ **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**

For myelodysplastic syndrome (MDS), answer the following:

Does the patient have low or intermediate-1 disease? ❑ **Yes** ❑ **No**
Is 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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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					
	Approved, through				
	Denied (documentation attached, if necessary)				
Tracking:					
1st Attempt		2nd Attempt		Letter Mailed:	