Jefferson Health Plans

2024 MEDICARE PRIOR AUTHORIZATION REQUEST FORM

Deferasirox - Medicare

Phone: 215-991-4300 **Fax back to: 866-371-3239**

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: ☐ Medicare	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	**Specialty/facility name (if applicable):**

☐ REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that applying the 72 hour standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:	
Strength:	
Directions / SIG:	

Please attach any pertinent medical history including labs and information for this member that may support approval.

Please answer the following questions and sign.

Q1. Is the medication being prescribed by or in consultation with r a hematologist, oncologist, or hepatologist?

☐ Yes ☐ No

Q2. Does the member have the diagnosis of treatment of chronic iron overload due to blood transfusions?

☐ Yes ☐ No

Q3. Is the member 2 years of age or older?

☐ Yes ☐ No

Q4. Is the member's creatinine clearance greater than 40 mL/min and serum creatinine less than twice the normal limit AND platelets greater than 50,000/mL?

☐ Yes ☐ No

Q5. Has documentation of serum ferritin levels consistently greater than 300 mcg/L been provided?

☐ Yes ☐ No

Jefferson Health Plans

2024 MEDICARE PRIOR AUTHORIZATION REQUEST FORM

Deferasirox - Medicare

Phone: 215-991-4300 **Fax back to: 866-371-3239**

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**

Q6. Does the member have the diagnosis of chronic iron overload in nontransfusion-dependent thalassemia syndromes?

☐ Yes ☐ No

Q7. Is the member 10 years of age or older?

☐ Yes ☐ No

Q8. Is the member's estimated glomerular filtration rate (GFR) greater than 40 mL/min and serum creatinine less than twice the normal limit AND platelets greater than 50,000/mL?

☐ Yes ☐ No

Q9. Has documentation of liver iron concentration (LIC) of at least 5 mg of iron per gram of liver dry weight (mg Fe/g dw) AND serum ferritin levels consistently greater than 300 mcg/L been provided?

☐ Yes ☐ No

Q10. Requested Duration:

☐ 12 months ☐ Other:

Q11. Additional Information:

Prescriber Signature

Date

2024 Medicare Prior Authorization Request