

MEDICARE ADVANTAGE PRIOR AUTHORIZATION REQUEST FORM

Deferiprone - 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.			
Member Name:	Prescriber Name:		
Member Number:	Fax:	Phone:	
Date of Birth:	Office Contact:		
Line of Business: Medicare Advantage	NPI:	State Lic ID:	
Address:	Address:		
City, State ZIP:	City, State ZIP:		
Primary Phone:	Specialty/facility name	Specialty/facility name (if applicable):	
REQUEST FOR EXPEDITED REVIEW: By checking this box and s he life or health of the enrollee or the enrollee's ability to regain n		ır standard review timeframe may seriously jeopardize	
Drug Name:			
Strength:			
Directions / SIG:			
Please attach any pertinent medical history in	ncluding labs and information for th swer the following questions and si		
Q1. Is deferiprone prescribed by or in o	consultation with hematologis	st?	
□Yes	□No		
Q2. Does the member have documenta syndromes, sickle cell disease or other		erload due to thalassemia	
☐ Yes	□ No		
Q3. Does the member have a documer equal to 1.5 x 1000000000 (10 to the n		il Count (ANC) greater than or	
☐ Yes	□No		
Q4. Requested Duration:			
☐ 12 months	☐ Other		
Q5. Additional Information:			



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Member Name:	Prescriber Name:
Prescriber Signature	Date
	v2025

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