Jefferson Health Plans

MEDICARE ADVANTAGE
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.

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 (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 a hematologist, oncologist, or hepatologist?

☐ Yes ☐ No

Q2. Does the patient have any of the following: a) estimated glomerular filtration rate (GFR) less than 40 mL/min or serum creatinine more than 2 times the age-appropriate upper normal limit; b) platelet counts less than 50,000/mL; c) high-risk myelodysplastic syndromes (MDS); d) advanced malignancies?

☐ Yes ☐ No

Q3. Does the patient have a diagnosis of treatment of chronic iron overload due to blood transfusions?

☐ Yes ☐ No

Q4. Is the patient 2 years of age or older?

☐ Yes ☐ No

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Member Name:	**Prescriber Name:**

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

☐ Yes ☐ No

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

☐ Yes ☐ No

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

☐ Yes ☐ No

Q8. 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 on 2 consecutive measurements 1 month apart?

☐ Yes ☐ No

Q9. Requested Duration:

☐ 12 Months ☐ Other:

Q10. Additional Information:

Prescriber Signature

Date

v2025