



Request for Prior Authorization
Deferasirox

(PLEASE PRINT - ACCURACY IS IMPORTANT)

Form with fields for IA Medicaid Member ID #, Patient name, DOB, Patient address, Provider NPI, Prescriber name, Phone, Prescriber address, Fax, Pharmacy name, Address, Phone, Pharmacy NPI, Pharmacy fax, NDC.

Prior authorization is required for deferasirox. Requests will only be considered for FDA approved dosing. Payment will be considered under the following conditions:

- 1) Patient does not have a serum creatinine greater than 2 times the age-appropriate upper limit of normal or creatinine clearance < 40mL/min; and 2) Patient does not have a poor performance status; and 3) Patient does not have a high-risk myelodysplastic syndrome; and 4) Patient does not have advanced malignancies; and 5) Patient does not have a platelet count < 50 x 10^9/L.

Preferred

Non-Preferred

Deferasirox Soluble Tablet

Deferasirox Packet Deferasirox Tablet

Exjade Jadenu

Strength

Dosage Instructions

Quantity

Days Supply

Patient has a diagnosis of iron overload related to anemia:

Yes (attach documentation) No (provide diagnosis):

Indicate member's current deferasirox treatment status: Initial Continuation

Patient's current weight in kg: Date obtained:

Serum Creatinine greater than 2 times the age-appropriate upper limit of normal?

Yes No Date obtained:

Creatinine Clearance: Date obtained:

Platelet Count: Date obtained:

Serum Ferritin: Date obtained: (attach labs dated within 30 days of request)

Does patient have poor performance status? Yes No

Does patient have high-risk myelodysplastic syndrome? Yes No

Does patient have advanced malignancies? Yes No

**Request for Prior Authorization-Continued
DEFERASIROX**

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Transfusional Iron Overload (in addition to above):

Initiation of Therapy: 1) Patient is 2 years of age or older; and 2) Patient has documentation of iron overload related to anemia (attach documentation); and 3) Patient has documentation of a recent history of frequent blood transfusions that has resulted in chronic iron overload; and 4) Serum ferritin is consistently > 1000 mcg/L (attach lab results dated within past month); and 5) Starting dose does not exceed: Exjade- 20mg/kg/day or Jadenu- 14mg/kg/day. Calculate dose to the nearest whole tablet. 6) Initial authorizations will be considered for up to 3 months. **Continuation of therapy:**

1) Serum ferritin has been measured within 30 days of continuation therapy request (attach lab results); and 2) Ferritin levels are > 500mcg/L and 3) Dose does not exceed: Exjade- 40mg/kg/day or Jadenu- 28mg/kg/day.

Initial Requests:

Patient has a recent history of frequent blood transfusions resulting in chronic iron overload?

Yes (provide recent transfusion dates) _____ No

Serum ferritin consistently > 1000 mcg/L: Yes No

Non-Transfusional Iron Overload (in addition to above)

Initiation of therapy: 1) Patient is 10 years of age or older; and 2) Patient has documentation of iron overload related to anemia (attach documentation); and 3) Serum ferritin and liver iron concentration (LIC) has been measured within 30 days of initiation (attach lab results); and 4) Serum ferritin levels are > 300mcg/L. 5) LIC are > 5mg Fe/g dw; and 6) Dose does not exceed: Exjade- 10mg/kg/day (if LIC is ≤ 15mg Fe/g dw) or 20mg/kg/day (if LIC is > 15mg Fe/g dw) or Jadenu- 7mg/kg/day (if LIC is ≤ 15mg Fe/g dw) or 14mg/kg/day (if LIC is > 15mg Fe/g dw). 7) Initial authorizations will be considered for up to 6 months. **Continuation of Therapy:**

1) Serum ferritin and LIC have been measured within 30 days of continuation therapy request; and 2) Serum ferritin levels are ≥ 300mcg/L; and 3) LIC is ≥ 3mg Fe/g dw; and 4) Dose does not exceed: Exjade- 10mg/kg/day (if LIC is 3 to 7mg Fe/g dw) or 20mg/kg/day (if LIC is > 7mg Fe/g dw) or Jadenu- 7mg/kg/day (if LIC is 3 to 7mg Fe/g dw) or 14mg/kg/day (if LIC is > 7mg Fe/g dw).

Initial & Renewal Requests:

LIC: _____ **Date obtained:** _____ (attach labs dated within 30 days of request)

Attach lab results and other documentation as necessary.

Prescriber signature (Must match prescriber listed above.)	Date of submission
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IMPORTANT NOTE: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.