IOWA Health and Human Services

Request for Prior Authorization
DEFERASIROX

FAX Completed Form To
1 (800) 574-2515
Provider Help Desk
1 (877) 776-1567

(PLEASE PRINT – ACCURACY IS IMPORTANT)

IA Medicaid Member ID #	Patient name	DOB
Patient address		
Provider NPI	Prescriber name	Phone
Prescriber address		Fax
Pharmacy name	Address	Phone
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.		
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 109/L.

Preferred
☐ Deferasirox Soluble Tablet

Non-Preferred
☐ Deferasirox Packet
☐ Exjade
☐ Deferasirox Tablet
☐ 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

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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

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 Health and Human Services, that the member continues to be eligible for Medicaid.*