15 Earhart Drive, Suite 101, Amherst, NY 14221

DEFERASIROX (EXJADE® AND JADENU®) AUTHORIZATION AND RE-AUTHORIZATION REQUEST

TEL: (716) 929-1000 | 1-800-809-4763 FAX: (716) 532-7360

Member Name:	Today's Date:	Date Needed:
Date of birth: Sex: Weight:	Prescriber:	Hospital/Clinic:
Home Phone Number: ( )	Phone Number: ( )	Fax Number: ( )
Home Address: City: State: Zip:	Address: City: State: Zip:	
Payor: ☐ Independent Health ☐ Anne Arundel Health System ☐ Pharmacy Benefit Dimensions ☐ Commercial ☐ Medicaid ☐ Medicare ☐ Self-funded Insurance ID: Group Number:	Prescriber specialty: Allergies:	

STATEMENT OF MEDICAL NECESSITY

Primary Diagnosis: _____

ICD 10 Code: _____

PLEASE SELECT ALL THAT APPLY:

☐ Patient has diagnosis of chronic iron overload associated with blood transfusions in patients with blood transfusion-dependent anemias, such as β-thalassemia, sickle cell disease, other rare anemias, and myeloproliferative disorders;

AND

as the recent transfusion of ~100mL/kg of packed red cells (~20 units for a 40kg patient) and a serum ferritin consistently greater than 1000mcg/L;

OR

☐ Patient is 10 years of age and older and has a diagnosis of non-transfusion-dependent thalassemia (NTDT) syndromes and with a liver iron (Fe) concentration (LIC) of at least 5 mg Fe per gram of liver dry weight and a serum ferritin greater than 300 mcg/L

FOR ALL PATIENTS, PLEASE SUBMIT THE FOLLOWING:

Baseline Serum Ferritin Level: _____ Date: _____
Baseline LFTs Level: _____ Date: _____
Baseline Bilirubin Level: _____ Date: _____
Baseline Serum Creatinine Level: _____ Date: _____
Baseline CBC Level: _____ Date: _____
Patient's Current Weight: _____ Date: _____

- Please submit documentation that patient has undergone auditory and ophthalmic testing (including slit lamp exam and dilated fundoscopy) before starting deferasirox therapy and provider attestation that patient will receive follow-up examinations as clinically indicated.

DRUG SELECTION

☐ New Authorization Request ☐ Reauthorization Request

☐ **Deferasirox** ☐ **EXJADE®** ☐ **JADENU®**

Dose: _____

Frequency: _____

PLEASE LIST ALL TRIED MEDICATIONS

_____

_____

FOR EXJADE ONLY:

Defarasirox tablets for oral suspension (generic Exjade) is a non-formulary medication. Has Patient tried and failed or have a contraindication to Deferasirox tablets or granules (generic Jadenu)? ☐ Yes ☐ No

FOR REAUTHORIZATION

Please submit the following from the past 3 months:

Current Serum Ferritin Level: _____ Date: _____
Current LFTs Level: _____ Date: _____
Current Bilirubin Level: _____ Date: _____
Current Serum Creatinine Level: _____ Date: _____
Current CBC Level: _____ Date: _____
Patient's Current Weight: _____ Date: _____