

MEDICAL PHARMACY PRIOR AUTHORIZATION REQUEST FORM

IRON CHELATION THERAPY

deferasirox (Exjade[®], Jadenu[®]), Jadenu[®], Ferriprox[®]

For authorization, please answer each question and fax this form PLUS chart notes back to the U of U Health Plans Prior Authorization Department. Failure to submit clinical documentation to support this request will result in delay and/or denial of the request.

- For **Medical Pharmacy** please fax requests to 801-213-1547.
- For **Retail Pharmacy** requests please fax requests to: 888-509-8142

If you have prior authorization questions, please call for assistance: Healthy U: 855-856-5694, University of Utah Health Employees: 855-856-5690, Individual & Family Plans: 855-869-4769, Commercial Groups: 855-859-4892, MHC: 855-885-7695, Advantage U Part B: 888-605-0858

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:	HCPCS Code:	

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Preferred: deferoxamine solution for injection, deferasirox tablets, deferasirox dispersible tablets

Non-preferred: Ferriprox[®] tablets and solution (deferiprone), deferasirox granules, oral packet

Dosing/Frequency: _____

If the request is for reauthorization, proceed to reauthorization section.

Questions	Yes	No	Comments/Notes
1. Does the member have a diagnosis that is approved by the US Food and Drug Administration?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
2. Is the prescriber a hematologist, or in consultation with one?	<input type="checkbox"/>	<input type="checkbox"/>	

DEFERASIROX TABLETS

1. Does the member have an eGFR <40mL/min/1.73 ² and/or platelet counts <50x10 ⁹ /L?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
2. Is the request for the indication of chronic iron overload due to blood transfusions? If NO, go to # 7.	<input type="checkbox"/>	<input type="checkbox"/>	
3. Is the member 2 years of age or older?	<input type="checkbox"/>	<input type="checkbox"/>	
4. Does the member have a history of receiving blood transfusions totaling ≥100mL/kg of packed red blood cells?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
5. Does the member have a serum ferritin ≥1000ng/mL before initiation of therapy on at least 2 consecutive measurements taken at least 1 month apart?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
6. Does the member have a liver iron concentration ≥5mg Fe/g dry weight determined by a liver biopsy or T2* MRI?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation

Confidentiality Notice

This document and any accompanying document contain confidential information and is intended for the use of the individual or entity named on this transmission sheet. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or the taking of any action in reliance on the contents of this information is strictly prohibited and the document should be returned to this office immediately. If you have received this facsimile in error, please notify us by telephone immediately and destroy document received.

7. Is the request for the indication of chronic iron overload with transfusion-independent thalassemia (non-transfusion-dependent thalassemia) syndromes?	<input type="checkbox"/>	<input type="checkbox"/>	
8. Is the member 10 years of age or older?	<input type="checkbox"/>	<input type="checkbox"/>	
9. Does the member have a liver iron concentration ≥ 5 mg Fe/g dry weight determined by a liver biopsy or T2* MRI?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
10. Does the member have a serum ferritin ≥ 300 ng/mL on at least 2 consecutive measurements taken at least 1 month apart?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
FERRIPROX®			
1. Is the member 18 years of age or older?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Does the member have a diagnosis of transfusion-dependent iron overload due to thalassemia syndromes?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
3. Has the member had an adequate trial and failure or contraindication/intolerance to deferasirox or deferoxamine?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
4. Is the member's initial absolute neutrophil count (ANC) $\geq 1.5 \times 10^9$ /L?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
5. Does the physician agree to monitor ANC levels while on therapy and to interrupt therapy if neutropenia or signs of infection develop?	<input type="checkbox"/>	<input type="checkbox"/>	
6. Does the member have a transfusion history of ≥ 100 mL/kg of packed red blood cells and a serum ferritin level $\geq 1,000$ ng/mL?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
7. Does the member have a liver iron concentration < 7 mg Fe/g dry weight determined by a liver biopsy or T2* MRI?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Is the member's current liver iron concentration < 3 mg Fe/g dry weight determined by a liver biopsy or T2* MRI or ferritin is ≤ 300 ng/mL?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			

Confidentiality Notice

This document and any accompanying document contain confidential information and is intended for the use of the individual or entity named on this transmission sheet. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or the taking of any action in reliance on the contents of this information is strictly prohibited and the document should be returned to this office immediately. If you have received this facsimile in error, please notify us by telephone immediately and destroy document received.

Additional information:

Physician Signature:

****Failure to submit clinical documentation to support this request will result in delay and/or denial of the request****

Policy PHARM-082
Origination Date: 02/11/2020
Reviewed/Revised Date: 10/28/2020
Next Review Date: 10/28/2021
Current Effective Date: 01/01/2020

Confidentiality Notice

This document and any accompanying document contain confidential information and is intended for the use of the individual or entity named on this transmission sheet. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or the taking of any action in reliance on the contents of this information is strictly prohibited and the document should be returned to this office immediately. If you have received this facsimile in error, please notify us by telephone immediately and destroy document received.