## 2024 MEDICARE 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.

Patient Name:		Prescriber Name:	Prescriber Name:	
Member Number:		Fax:	Phone:	
Date of Birth:		Office Contact:	Office Contact:	
Line of Business:	□ Medicare	NPI:	State Lic ID:	
Address:		Address:	Address:	
City, State ZIP:		City, State ZIP:	City, State ZIP:	
Primary Phone:		Specialty/facility nan	Specialty/facility name (if applicable):	
	DITED REVIEW: By checking this box and s nrollee or the enrollee's ability to regain n		our standard review timeframe may seriously jeopardize	
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 r a hematologist, oncologist, or hepatologist?				
☐ Yes		□No	□ No	
Q2. Does the member have the diagnosis of treatment of chronic iron overload due to blood transfusions?				
□Yes		☐ No		
Q3. Is the me	ember 2 years of age or old	der?		
□Yes		□No		
Q4. Is the member's creatinine clearance greater than 40 mL/min and serum creatinine less than twice the normal limit AND platelets greater than 50,000/mL?				
☐ Yes		☐ No	□ No	
Q5. Has documentation of serum ferritin levels consistently greater than 300 mcg/L been provided?				
☐Yes		☐ No		

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Patient Name:	Prescriber Name:			
Q6. Does the member have the diagnosis of chronic iron overload in nontransfusion-dependent thalassemia syndromes?				
☐ Yes	□ No			
Q7. Is the member 10 years of age or older?				
☐ Yes	□ No			
Q8. Is the member's estimated glomerular filtration rate (GFR) greater than 40 mL/min and serum creatinine less than twice the normal limit AND platelets greater than 50,000/mL?				
☐ Yes	□No			
Q9. 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?				
☐ Yes	□ No			
Q10. Requested Duration:				
☐ 12 months	☐ Other:			
Q11. Additional Information:				
Prescriber Signature	Date			

2024 Medicare Prior Authorization Request