

2024 MEDICARE PRIOR AUTHORIZATION REQUEST FORM

Deferiprone - 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 re-

Patient Name:	Prescriber Name:	
Member Number:	Fax: Phone:	
Date of Birth:	Office Contact:	
Line of Business: Medicare	NPI: State Lic ID:	
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	
☐ REQUEST FOR EXPEDITED REVIEW: By checking this both the life or health of the enrollee or the enrollee's ability to r	c and signing below, I certify that applying the 72 hour standard review timeframe may seriously jeop egain maximum function.	ardize
Drug Name:		
Strength:		
Directions / SIG:		
	ory including labs and information for this member that may support approva e answer the following questions and sign.	al.
Q1. Is deferiprone prescribed by or	in consultation with hematologist?	
☐ Yes	□ No	
Q2. Does the member have docum syndromes, sickle cell disease or c	entation of transfusional iron overload due to thalassemia ther anemias?	
☐ Yes	□ No	
Q3. Does the member have a docuequal to 1.5 x 1000000000 (10 to t	mentation of Absolute Neutrophil Count (ANC) greater than one ninth power) per liter?	r
☐ Yes	□ No	
Q4. Duration:		
☐ 12 months	☐ Other	
Q5. Additional Information:		

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Patient Name:	Prescriber Name:
Prescriber Signature	Date
	2024 Medicare Prior Authorization Request