

Fax completed form to: 1-866-868-0858  
Questions, please call: 1-866-316-6049

**GENERATIONS HEALTHCARE**

**Important Information About Prescription Drug Coverage**

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To: \_\_\_\_\_ From: \_\_\_\_\_

Fax: \_\_\_\_\_ Pages: \_\_\_\_\_

Re: Exjade® (Deferasirox): Prior Authorization Request Form: Please respond.

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- Please complete the attached Exjade® (Deferasirox) Prior Authorization Request Form
- To expedite the review process please complete all requested fields.
- Completed forms should be faxed to: 1-866-868-0858. It is not necessary to fax this cover page.

**Please note:** By signing the attached form you are certifying that the treatment requested is medically necessary. No contraindications are present and precautions have been considered. You will be supervising the patient's treatment. Supporting documentation is available in the patient's record. Signature on this form attests to the fact that the corresponding ICD-9 code has been documented in the patients chart and submitted on a CMS- 1500 form.

**Information about this drug**

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**Exjade®(Deferasirox)**

Exjade® has not been well studied in geriatric patients (65 years of age and older). Exjade® should be used cautiously in the elderly population due to an increased risk of acute renal failure.

You can make an expedited request by indicating this at the top of the attached form. If you request an expedited review, and sign the attached form, you certify that applying the 72 hour standard review time frame may seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

**Information on the attached form is protected health information and subject to all privacy and security regulations under HIPAA.**

# Prior Authorization Request Form

Fax completed form to 1-866-868-0858 Need help? Call 1-866-316-6049

## Patient Information

Name \_\_\_\_\_  
Member ID \_\_\_\_\_  
Medicare ID \_\_\_\_\_  
Date of birth \_\_\_\_\_ Sex: M / F  
Address \_\_\_\_\_  
City \_\_\_\_\_  
State \_\_\_\_\_ ZIP \_\_\_\_\_  
Phone \_\_\_\_\_  
Nursing home resident? YES / NO  
Home care patient? YES / NO

## Prescriber and Pharmacy Information

Name \_\_\_\_\_  
Specialty \_\_\_\_\_  
DEA \_\_\_\_\_  
NPI \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_  
State \_\_\_\_\_ ZIP \_\_\_\_\_  
Phone \_\_\_\_\_ Fax \_\_\_\_\_  
Pharmacy name \_\_\_\_\_  
NCPDP \_\_\_\_\_  
NPI \_\_\_\_\_  
Phone \_\_\_\_\_ Fax \_\_\_\_\_

## All items below this line are for Physician Use Only

### Information for Requested Drug

Strength: \_\_\_\_\_ Dosage form: \_\_\_\_\_ Qty per 30 days: \_\_\_\_\_ Drug is (circle one): Newly prescribed/Refill  
Directions: \_\_\_\_\_ Diagnosis: \_\_\_\_\_ ICD-9 Code: \_\_\_\_\_

Standard Reviews will be completed in under 72 hours. An expedited review is available if you certify that a standard review timeframe will seriously jeopardize the health of your patient. To request an expedited review, simply indicate this at the top of this page.

### Exjade®(Deferasirox) Criteria

- 1 Please indicate the patient's diagnosis. Select or indicate the correct ICD-9 code. This question must be answered.  
 Presence of chronic iron overload due to blood transfusions associated with beta-thalassemia and other congenital or chronic anemias, including myelodysplastic syndrome (ICD-9: 282.4, 282.6, 238.7). (Chronic overload defined as transfusion necessity of approximately 100 milliliters/kilogram (kg) of packed red blood cells (approximately 20 units for a 40 kg patient) and a serum ferritin level consistently greater than 1000 micrograms/liter).  
 Other: \_\_\_\_\_
- 2 Is the prescribing physician a hematologist/oncologist or has one been consulted?  
 Yes  No
- 3 Does the patient have a history of hypersensitivity to Exjade®?  
 Yes  No
- 4 Has the patient failed to receive a clinically appropriate therapeutic response OR demonstrated intolerance (e.g., allergy, hypersensitivity, adverse effect(s), development of a contraindication) from deferoxamine injection?  
 Yes  No

Medical justification: (Attach additional page if necessary): \_\_\_\_\_  
\_\_\_\_\_

Prescriber's signature: \_\_\_\_\_ Date: \_\_\_\_\_