

PAA-1030

Iowa Department of Human Services

Deferasirox

Iowa Health Link

FAX Completed Form To 1 (877) 733-3195 Provider Help Desk 1 (844) 236-1464 **Request for Prior Authorization**

(PLEASE PRINT - ACCURACY IS IMPORTANT)

IA Medicaid Member ID #	Patient name	DOB	
Patient address			
Provider NPI	Prescriber name	Phone	
Prescriber address		Fax	
Pharmacy name	Address	Phone	
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.			
Pharmacy NPI	Pharmacy fax NDC		
Prior authorization is required for deferasirox. Requests will only be considered for FDA approved dosing. Payment will be considered under the following conditions: 1) Patient does not have a serum creatinine greater than 2 times the age-appropriate upper limit of normal or creatinine clearance < 40mL/min; and 2) Patient does not have a poor performance status; and 3) Patient does not have a high-risk myelodysplastic syndrome; and 4) Patient does not have advanced malignancies; and 5) Patient does not have a platelet count < 50 x 10 ⁹ /L.			
<u>Preferred</u>	Non-Preferred		
 □ Deferisirox Soluble Tablet □ Deferasirox Packet □ Deferasirox Tablet 			
	☐ Exjade ☐ Jader	าน	
Strength	Dosage Instructions Quantity	Days Supply	
Patient has a diagnosis of iron overload related to anemia: Yes (attach documentation) No (provide diagnosis): Indicate member's current deferasirox treatment status: Initial Continuation			
Patient's current weight in kg: Date obtained:			
Serum Creatinine greater than 2 times the age-appropriate upper limit of normal? Yes No Date obtained:			
Creatinine Clearance:	Date obtained:		
Platelet Count:	Date obtained:	Date obtained:	
Serum Ferritin:	Date obtained:	Date obtained:(attach labs dated within 30 days of request)	
(attach labs dated within 30 days of request)			
Does patient have poor perform	rmance status?	No	
Does patient have high-risk myelodysplastic syndrome?			
Does patient have advanced r	malignancies?	No	

Request for Prior Authorization-Continued DEFERASIROX

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☐ Transfusional Iron Overload (in addition to above):			
Initiation of Therapy: 1) Patient is 2 years of age or older; and 2) Patient has documentation of iron overload related to anemia (attach documentation); and 3) Patient has documentation of a recent history of frequent blood transfusions that has resulted in chronic iron overload; and 4) Serum ferritin is consistently > 1000 mcg/L (attach lab results dated within past month); and 5) Starting dose does not exceed: Exjade- 20mg/kg/day or Jadenu-14mg/kg/day. Calculate dose to the nearest whole tablet. 6) Initial authorizations will be considered for up to 3 months. Continuation of therapy: 1) Serum ferritin has been measured within 30 days of continuation therapy request (attach lab results); and 2) Ferritin levels are > 500mcg/L and 3) Dose does not exceed: Exjade- 40mg/kg/day or Jadenu- 28mg/kg/day.			
Initial Requests:			
Patient has a recent history of frequent blood transfusions resulti Yes (provide recent transfusion dates)			
Serum ferritin consistently > 1000 mcg/L:			
Non-Transfusional Iron Overload (in addition to above) Initiation of therapy: 1) Patient is 10 years of age or older; and 2) Patient has documentation of iron overload related to anemia (attach documentation); and 3) Serum ferritin and liver iron concentration (LIC) has been measured within 30 days of initiation (attach lab results); and 4) Serum ferritin levels are > 300mcg/L. 5) LIC are			
> 5mg Fe/g dw; and 6) Dose does not exceed: Exjade- 10mg/kg/day (if LIC is ≤ 15mg Fe/g dw) or 20mg/kg/day (if LIC is > 15mg Fe/g dw) or Jadenu- 7mg/kg/day (if LIC is ≤ 15mg Fe/g dw) or 14mg/kg/day (if LIC is > 15mg Fe/g dw). 7) Initial authorizations will be considered for up to 6 months. Continuation of Therapy: 1) Serum ferritin and LIC have been measured within 30 days of continuation therapy request; and 2) Serum ferritin levels are ≥ 300mcg/L; and 3) LIC is ≥ 3mg Fe/g dw; and 4) Dose does not exceed: Exjade- 10mg/kg/day (if LIC is 3 to 7mg Fe/g dw) or Jadenu- 7mg/kg/day (if LIC is 3 to 7mg Fe/g dw) or 14mg/kg/day (if LIC is > 7mg Fe/g dw).			
Initial & Renewal Requests:			
C: Date obtained: (attach labs dated within 30 days of request)			
Attach lab results and other documentation as necessary.			
Prescriber signature (Must match prescriber listed above.)	Date of submission		

IMPORTANT NOTE: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.

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