HEALTHY U CHIP

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 Healthy U CHIP Prior Authorization Department.

- For **Medical Pharmacy** please fax requests to: 801-213-1547
- For **Retail Pharmacy** please fax requests to: 385-425-4052

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for Pharmacy Customer Service for assistance at 385-425-5094

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

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?	☐	☐	**Please provide documentation**
2. Is the prescriber a hematologist, or in consultation with one?	☐	☐	
DEFERASIROX TABLETS			
1. Does the member have an eGFR <40mL/min/1.73^2 and/or platelet counts <50x10^9/L?	☐	☐	**Please provide documentation**
2. Is the request for the indication of chronic iron overload due to blood transfusions? **If NO, go to # 6**.	☐	☐	
3. Does the member have a history of receiving blood transfusions totaling ≥100mL/kg of packed red blood cells?	☐	☐	**Please provide documentation**
4. 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?	☐	☐	**Please provide documentation**
5. Does the member have a liver iron concentration ≥5mg Fe/g dry weight determined by a liver biopsy, T2* MRI, or FerriScan?	☐	☐	**Please provide documentation**
6. Is the request for the indication of chronic iron overload with transfusion-independent thalassemia (non-transfusion-dependent thalassemia) syndromes?	☐	☐	

7. Is the member 10 years of age or older?	☐	☐	
8. Does the member have a liver iron concentration ≥5mg Fe/g dry weight determined by a liver biopsy, T2* MRI, or FerriScan?	☐	☐	**Please provide documentation**
9. Does the member have a serum ferritin ≥300ng/mL on at least 2 consecutive measurements taken at least 1 month apart?	☐	☐	**Please provide documentation**
FERRIPROX®			
1. Does the member have a diagnosis of transfusion-dependent iron overload due to thalassemia syndromes?	☐	☐	**Please provide documentation**
2. Has the member had an adequate trial and failure or contraindication/intolerance to deferasirox or deferoxamine?	☐	☐	**Please provide documentation**
3. Is the member's initial absolute neutrophil count (ANC) ≥1.5x10^9/L?	☐	☐	**Please provide documentation**
4. Does the physician agree to monitor ANC levels while on therapy and to interrupt therapy if neutropenia or signs of infection develop?	☐	☐	
5. Does the member have a transfusion history of ≥100mL/kg of packed red blood cells and a serum ferritin level ≥1,000ng/mL?	☐	☐	**Please provide documentation**
6. Does the member have a liver iron concentration<7mg Fe/g dry weight determined by a liver biopsy, T2* MRI, FerriScan?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Is the member's current liver iron concentration < 3 mg Fe/g dry weight determined by a liver biopsy, T2* MRI, or FerriScan or ferritin is ≤ 300ng/mL?	☐	☐	**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.			
Additional information:			
Physician Signature:			

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Policy: PHARM-CHIP-082
Origination Date: 07/01/2024
Reviewed/Revised Date:
Next Review Date:
Current Effective Date: 07/01/2024