



Prior Authorization Form

Exjade®

ONLY COMPLETED REQUESTS WILL BE REVIEWED

Drug Requested: Exjade®

Date: _____

Patient ID#: _____ DOB: _____

Patient Name: _____

Provider NPI: _____

Prescribing Physician: _____

Office Contact: _____

Office Fax #: _____

Office Phone: _____

ONLY COMPLETED REQUESTS WILL BE REVIEWED

1. DIAGNOSIS FOR DRUG REQUESTED:

- Chronic Iron overload due to blood transfusions
 Other (specify) _____

2. PATIENT HISTORY:

a. Is the patient's serum ferritin level consistently greater than 1000mcg/L (as demonstrated with at least 2 lab values in the previous 2 months)? Yes No

Lab 1 _____ Ref. Range _____ Date _____

Lab 2 _____ Ref. Range _____ Date _____

Please add any other supporting medical information that may be useful in the decision-making process:

Three horizontal lines for providing additional medical information.

FAX TO (888) 671-5285. YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX OR MAIL.

Internal use only section with fields for Document #, Coverage effective date, Processor Initials, Date, M F Rx coverage, Y N, STANDARD - SELECT, LOB, Previous Auth, Y N, Approved, Reviewer Initials, Date.