



Prior Authorization Form

Exjade®/Ferriprox®

ONLY COMPLETED REQUESTS WILL BE REVIEWED

Drug Requested: [ ] Exjade® [ ] Ferriprox®
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
[ ] Transfusional Iron overload due to thalassemia syndromes
[ ] 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 \_\_\_\_\_
b. Is current chelation therapy inadequate? [ ] Yes [ ] No

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

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