FUTURE SCRIPTS

Please complete ALL information below and fax your request to 1-888-671-5285

Exjade® & Jadenu® Prior Authorization Request Form (Page 1 of 2)

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if **generic substitution** is acceptable	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

❑ Chronic iron overload due to blood transfusions
❑ Chronic iron overload in non-transfusion-dependent thalassemia syndromes
❑ Other diagnosis: _____ ICD-10 Code(s): _____

For chronic iron overload due to blood transfusions, answer the following:

Does the patient have serum ferritin levels that are consistently greater than 1000 mcg/L (as demonstrated with at least two lab values within two months prior to treatment)? ❑ **Yes** ❑ **No**

Serum ferritin:
Lab Value #1: _____ Date: _____
Lab Value #2: _____ Date: _____

Continuation:

Does the patient have a decreased serum ferritin level compared with the baseline level? ❑ **Yes** ❑ **No**

Serum ferritin:
Baseline Lab Value (prior to treatment): _____ Date: _____
Lab Value (while on treatment): _____ Date: _____

For chronic iron overload in non-transfusion-dependent thalassemia syndromes, answer the following:

Does the patient have serum ferritin levels that are consistently greater than 300 mcg/L and liver iron concentration (LIC) of at least 5 milligrams of iron per gram of liver dry weight (mg Fe/g dw) (as demonstrated with at least two lab values within two months prior to treatment)? ❑ **Yes** ❑ **No**

Serum ferritin:
Lab Value #1: _____ Date: _____
Lab Value #2: _____ Date: _____
Liver iron concentration:
Lab Value #1: _____ Date: _____
Lab Value #2: _____ Date: _____

<continued on next page>

Exjade® & Jadenu® Prior Authorization Request Form (Page 2 of 2)

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

<continued from previous page>

Continuation:

Does the patient have a decreased serum ferritin level compared with the baseline level or reduction in LIC (liver iron concentration)? ❑ **Yes** ❑ **No**

Serum ferritin:

Baseline Lab Value (prior to treatment): _____ Date: _____

Lab Value (while on treatment): _____ Date: _____

Liver iron concentration:

Baseline Lab Value (prior to treatment): _____ Date: _____

Lab Value (while on treatment): _____ Date: _____

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.