



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

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

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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:
<input type="checkbox"/> Check if generic substitution is acceptable		Directions for Use:	
<input type="checkbox"/> 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: _____

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This document and others if attached contain information that is privileged, confidential and/or may contain protected health information (PHI). The Provider named above is required to safeguard PHI by applicable law. The information in this document is for the sole use of FutureScripts. Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. **If you are not the intended recipient, please notify the sender immediately.**

Office use only: Exjade-Jadenu_FS_2018Feb-W



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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.