Jadenu/Jadenu Sprinkles (deferasirox)
Prior Authorization Request Form

Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

☐ **URGENT**

MEMBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PHONE NUMBER:	**DATE OF BIRTH:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
PATIENT INSURANCE ID NUMBER:	

☐ **MALE** ☐ **FEMALE** **HEIGHT (IN/CM):** _____ **WEIGHT (LB/KG):** _____ **ALLERGIES:** _____

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: HTTPS://MAGELLANRX.COM/MEMBER/EXTERNAL/COMMERCIAL/COMMON/DOC/EN-US/PHI_DISCLOSURE_AUTHORIZATION.PDF

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): _____
AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: _____

PRESCRIBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PRESCRIBER SPECIALTY:	**EMAIL ADDRESS:**
NPI NUMBER:	**DEA NUMBER:**
PHONE NUMBER:	**FAX NUMBER:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
REQUESTOR (if different than prescriber)**:**	**OFFICE CONTACT PERSON:**

MEDICATION OR MEDICAL DISPENSING INFORMATION			
MEDICATION NAME:			
DOSE/STRENGTH:	**FREQUENCY:**	**LENGTH OF THERAPY/REFILLS:**	**QUANTITY:**
☐ **NEW THERAPY** ☐ **RENEWAL** DURATION OF THERAPY (SPECIFIC DATES):		**IF RENEWAL:** DATE THERAPY INITIATED:	

Continued on next page.

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MEMBER'S LAST NAME: _____ **MEMBER'S FIRST NAME:** _____

1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? ☐ YES (if yes, complete below) ☐ NO		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE)**:**	**DURATION OF THERAPY** (SPECIFY DATES)**:**	**RESPONSE/REASON FOR FAILURE/ALLERGY:**

2. LIST DIAGNOSES:	**ICD-10:**
□ Chronic iron overload due to blood transfusions (transfusional hemosiderosis) □ Chronic iron overload due to non-transfusion-dependent thalassemia (NTDT) □ Other diagnosis: _____ ICD-10 Code(s): _____	

3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.

Does the patient have a creatinine clearance < 40 mL/minute or a creatinine greater than 2x the upper limit of normal?* □ Yes □ No
Documentation is required

Does the patient have a platelet count of less than 50 x 10^9/L?* □ Yes □ No
Documentation is required

For chronic iron overload due to blood transfusions (transfusional hemosiderosis), also answer the following:
Does the patient have a baseline ferritin level of 1,000 mcg/L or more?* □ Yes □ No
Documentation is required

Has the patient required 20 or more transfusions? □ Yes □ No

Does the patient have a liver iron concentration (LIC) of or exceeding 2 mg of iron per gram of liver dry weight, based on MRI confirmation or liver biopsy results? □ Yes □ No

Reauthorization:
Has the patient experienced a reduction, from baseline, in serum ferritin level?* □ Yes □ No
***Documentation is required**

For chronic iron overload due to non-transfusion-dependent thalassemia (NTDT), also answer the following:
Does the patient have a liver iron concentration (LIC) of 5 mg of iron per gram of liver dry weight (mg Fe/g dw) or higher, based on liver biopsy results? □ Yes □ No
Does the patient have a serum ferritin level > 300 mcg/L? □ Yes □ No

Reauthorization:
Does the patient have a follow-up liver biopsy with a liver iron concentration (LIC) of 3 mg Fe/g dw or higher? □ Yes □ No

Has the patient experienced a reduction, from baseline, in serum ferritin level or LIC? □ Yes □ No

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: Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received.

ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature or Electronic I.D. Verification: _____ Date: _____

FAX THIS FORM TO: 800-424-7640
MAIL REQUESTS TO: Magellan Rx Management Prior Authorization Program
Attn: CP–4201
P.O. Box 64811
St. Paul, MN 55164-0811