

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 NU	IMBER:				
IF YOU ARE NOT THE PATIENT OR THE PRESC	IGHT (IN/CM): WEIG ERIBER, YOU WILL NEED TO SUBMIT A PHI DISCL DM/MEMBER/EXTERNAL/COMMERCIAL/COMM	OSURE AUTHORIZATION FORM WITH THIS REQ	UEST WHICH CAN BE FOUND AT THE		
PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE):					
PRESCRIBER INFORMATION					
LAST NAME:		FIRST NAME:			
PRESCRIBER SPECIALTY:		EMAIL ADDRESS:			
NPI NUMBER:		DEA NUMBER:			
PHONE NUMBER:		FAX NUMBER:			
STREET ADDRESS:	_	1			
CITY:		STATE: ZIP CODE:			
REQUESTOR (if different than prescriber):		OFFICE CONTACT PERSON:			
MEDICATION OR MEDICAL	DISPENSING INFORMATION				
MEDICATION NAME:					
DOSE/STRENGTH:	FREQUENCY:	LENGTH OF	QUANTITY:		
. ,		THERAPY/REFILLS:	,		
NEW THERAPY	RENEWAL	IF RENEWAL: DATE THERAPY	'INITIATED:		
DURATION OF THERAPY (SP	ECIFIC DATES):				

Continued on next page.



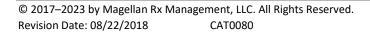


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MEMBER'S LAST NAME: MEMBER'S FIRST NAME:				
1. HAS THE PATIENT TRIED ANY OTHER	R MEDICATIONS FOR THIS CONDITION?	YES (if yes, complete below) NO		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE):	DURATION OF THERAPY (SPECIFY DATES):	RESPONSE/REASON FOR FAILURE/ALLERGY:		
2. LIST DIAGNOSES:	ICD-10:			
□ Chronic iron overload due to blood transf□ Chronic iron overload due to non-transfu□ Other diagnosis:				
PRIOR AUTHORIZATION.	: PLEASE PROVIDE ALL RELEVANT CLINICA			
normal?* □ Yes □ No *Documentation is required	e of loss than 50 x 1009/L2* \Box Vos \Box No	reater than 2x the upper limit of		
Does the patient have a platelet count of less than 50 x 10^9/L?* □ Yes □ No *Documentation is required				
	l transfusions (transfusional hemosidere in level of 1,000 mcg/L or more?* ☐ Yes			
Has the patient required 20 or more tr	ansfusions? Yes No			
Does the patient have a liver iron cond based on MRI confirmation or liver bid	centration (LIC) of or exceeding 2 mg of opsy results? Yes No	iron per gram of liver dry weight,		
Reauthorization: Has the patient experienced a reduction *Documentation is required	on, from baseline, in serum ferritin leve	l?* □ Yes □ No		
				
Reauthorization: Does the patient have a follow-up live Yes No	r biopsy with a liver iron concentration	(LIC) of 3 mg Fe/g dw or higher?		
Has the patient experienced a reduction, from baseline, in serum ferritin level or LIC? $\ \square$ Yes $\ \square$ No				







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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:

CONFIDENTIALITY NOTICE: The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately (via return FAX) and arrange for the return or destruction of these documents.

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

