



**Reblozyl (Iusatercept-aamt)  
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](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:
<input type="checkbox"/> NEW THERAPY	<input type="checkbox"/> RENEWAL	IF RENEWAL: DATE THERAPY INITIATED:	
DURATION OF THERAPY (SPECIFIC DATES):			

Continued on next page





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MEMBER'S LAST NAME: \_\_\_\_\_ MEMBER'S FIRST NAME: \_\_\_\_\_

<b>1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION?</b> <input type="checkbox"/> YES (if yes, complete below) <input type="checkbox"/> NO		
<b>MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE):</b>  	<b>DURATION OF THERAPY (SPECIFY DATES):</b>  	<b>RESPONSE/REASON FOR FAILURE/ALLERGY:</b>  
<b>2. LIST DIAGNOSES:</b> <input type="checkbox"/> Transfusion-dependent beta-thalassemia <input type="checkbox"/> Other diagnosis: _____ ICD-10 _____		<b>ICD-10:</b>  
<b>3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.</b>		
<b>Clinical Information:</b>  <b>Does the patient have Sickle cell beta-thalassemia (Hemoglobin S/ beta-thalassemia) OR alpha-thalassemia (Hemoglobin H disease)?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No  <b>Has the patient received 6-20 red blood cell units via transfusion over the past 24 weeks?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Please submit documentation</i>  <b>Has the patient went longer 35 days without a transfusion in the past 6 months?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Please submit documentation</i>  <b>Has the patient received hydroxyurea in the past 6 months?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No  <b>Has the patient required medical treatment for a Deep Vein Thrombosis (DVT) or for a stroke in the past 6 months?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No  <b>Is the patient Eastern Cooperative Oncology Group (ECOG) performance status of 0 or 1 (is ambulatory and can carry out light work activities)?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Please submit documentation</i>  <b>Is the patient currently on chronic anticoagulation therapy?(Note: This does NOT include surgical prophylaxis, LMW heparin for superficial venous thrombosis or daily aspirin therapy)</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?</b>  <hr/> <hr/>		
<b>*Please note:</b> Not all drugs/diagnoses are covered on all plans. This request may be denied unless all required information is received.		





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**MEMBER'S LAST NAME:** \_\_\_\_\_ **MEMBER'S FIRST NAME:** \_\_\_\_\_

**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; c/o Magellan Health, Inc.  
4801 E. Washington Street, Phoenix, AZ 85034  
Phone: 877-228-7909

