



**MEDICARE ADVANTAGE
PRIOR AUTHORIZATION REQUEST FORM**

Deferasirox - Medicare

Phone: 215-991-4300

Fax back to: 866-371-3239

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Member Name:	Prescriber Name:	
Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Line of Business: <input type="checkbox"/> Medicare Advantage	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that applying the 72 hour standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:	
Strength:	
Directions / SIG:	

**Please attach any pertinent medical history including labs and information for this member that may support approval.
Please answer the following questions and sign.**

Q1. Is the medication being prescribed by or in consultation with r a hematologist, oncologist, or hepatologist?

Yes

No

Q2. Does the member have the diagnosis of treatment of chronic iron overload due to blood transfusions?

Yes

No

Q3. Is the member 2 years of age or older?

Yes

No

Q4. Is the member's creatinine clearance greater than 40 mL/min and serum creatinine less than twice the normal limit AND platelets greater than 50,000/mL?

Yes

No

Q5. Has documentation of serum ferritin levels consistently greater than 300 mcg/L been provided?



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Member Name:	Prescriber Name:
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q6. Does the member have the diagnosis of chronic iron overload in nontransfusion-dependent thalassemia syndromes?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q7. Is the member 10 years of age or older?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q8. Is the member's estimated glomerular filtration rate (GFR) greater than 40 mL/min and serum creatinine less than twice the normal limit AND platelets greater than 50,000/mL?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q9. Has documentation of liver iron concentration (LIC) of at least 5 mg of iron per gram of liver dry weight (mg Fe/g dw) AND serum ferritin levels consistently greater than 300 mcg/L been provided?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q10. Requested Duration:	
<input type="checkbox"/> 12 Months	<input type="checkbox"/> Other:
Q11. Additional Information:	

Prescriber Signature

Date

v2025