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Visit [go.covermymeds.com/OptumRx](http://go.covermymeds.com/OptumRx) to begin using this free service.

Please note: All information below is required to process this request.

Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

# Exjade<sup>®</sup>, Jadenu<sup>®</sup>, Jadenu<sup>®</sup> Sprinkle 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 requesting <b>brand</b>			Directions for Use:		
<input type="checkbox"/> Check if request is for <b>continuation of therapy</b>					
Clinical Information (required)					
<b>Select the diagnosis below:</b>					
<input type="checkbox"/> Chronic iron overload due to blood transfusions (transfusional hemosiderosis)					
<input type="checkbox"/> Chronic iron overload due to non-transfusion-dependent thalassemia (NTDT)					
<input type="checkbox"/> Myelodysplastic syndrome (MDS)					
<input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____					
<b>For chronic iron overload due to blood transfusions (transfusional hemosiderosis), answer the following:</b>					
Does the patient have a baseline ferritin level more than 1,000 mcg/L? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Has the patient required a transfusion of at least 100 mL/kg packed red blood cells? <input type="checkbox"/> Yes <input type="checkbox"/> No					
<b>Reauthorization:</b>					
Has the patient experienced a reduction, from baseline, in serum ferritin level or liver iron concentration (LIC)? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Is there documentation of positive clinical response with therapy of the requested medication? <input type="checkbox"/> Yes <input type="checkbox"/> No					
<b>For chronic iron overload due to non-transfusion-dependent thalassemia (NTDT), answer the following:</b>					
Does the patient have a liver iron concentration (LIC) of 5 milligrams iron per gram of liver dry weight (mg Fe/g dw) or higher? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If <b>yes</b> , is this prior to initiation of treatment with the requested drug? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Does the patient have a serum ferritin level greater than 300 mcg/L? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If <b>yes</b> , is this prior to initiation of treatment with the requested drug? <input type="checkbox"/> Yes <input type="checkbox"/> No					
<b>Reauthorization:</b>					
Does the patient have a LIC of 3 mg Fe/g dw or higher? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Has the patient experienced a reduction, from baseline, in serum ferritin level or liver iron concentration (LIC)? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Is there documentation of positive clinical response with therapy of requested medication? <input type="checkbox"/> Yes <input type="checkbox"/> No					
<b>For myelodysplastic syndrome (MDS), answer the following:</b>					
Does the patient have low or intermediate-1 disease? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Is the patient a potential transplant patient? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Has the patient received more than 20 red blood cell transfusions? <input type="checkbox"/> Yes <input type="checkbox"/> No					
<b>Reauthorization:</b>					
Has the patient experienced a reduction, from baseline, in serum ferritin level or liver iron concentration (LIC)? <input type="checkbox"/> Yes <input type="checkbox"/> No					

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 OptumRx. 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\_Comm\_2018Feb-W



## Exjade<sup>®</sup>, Jadenu<sup>®</sup>, Jadenu<sup>®</sup> Sprinkle Prior Authorization Request Form (Page 2 of 2)

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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?

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Please note: This request may be denied unless all required information is received.  
For urgent or expedited requests please call 1-800-711-4555.  
This form may be used for non-urgent requests and faxed to 1-800-527-0531.