OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.
Visit 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® Prior Authorization Request Form (Page 1 of 2)

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)

Member Name:		
Insurance ID#:		
Date of Birth:		
Street Address:		
City:	State:	Zip:
Phone:		

Provider Information (required)

Provider Name:		
NPI#:	Specialty:	
Office Phone:		
Office Fax:		
Office Street Address:		
City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

❑ Chronic iron overload due to blood transfusions (transfusional iron overload)
❑ Chronic iron overload in non-transfusion-dependent thalassemia syndromes
❑ Myelodysplastic syndrome (MDS)
❑ Other diagnosis: _____ ICD-10 Code(s): _____

For chronic iron overload due to blood transfusions (transfusional iron overload), answer the following:

Does the patient have chronic iron overload (e.g., sickle cell anemia, thalassemia, etc.) due to blood transfusion (transfusional hemosiderosis)? ❑ **Yes** ❑ **No**

Has the patient had blood transfusion of at least 100 mL/kg of packed red blood cells (e.g., at least 20 units of packed red blood cells for a 40 kg person or more in individuals weighing more than 40 kg) prior to initiation of treatment with Exjade? ❑ **Yes** ❑ **No**

Does the patient have serum ferritin levels consistently greater than 1000 mcg/L prior to initiation of treatment with Exjade (baseline ferritin level)? ❑ **Yes** ❑ **No**

Does the patient have a trial and failure or intolerance to parenteral Desferal (deferoxamine mesylate) therapy? ❑ **Yes** ❑ **No**

Is Exjade prescribed by a hematologist/oncologist or hepatologist? ❑ **Yes** ❑ **No**

Reauthorization:

Is there documentation the patient has had a positive clinical response to therapy? ❑ **Yes** ❑ **No**

Has the patient experienced a reduction from baseline in serum ferritin level or liver iron concentration (LIC)? ❑ **Yes** ❑ **No**

For chronic iron overload in non-transfusion-dependent thalassemia syndromes, answer the following:

Does the patient have liver iron (Fe) concentration (LIC) levels consistently greater than or equal to 5 mg Fe per gram of dry weight (mg Fe/g dw) prior to initiation of treatment with Exjade? ❑ **Yes** ❑ **No**

Does the patient have serum ferritin levels consistently greater than 300 mcg/L prior to initiation of treatment with Exjade? ❑ **Yes** ❑ **No**

Is Exjade prescribed by a hematologist/oncologist or hepatologist? ❑ **Yes** ❑ **No**

Reauthorization:

Is there documentation the patient has had a positive clinical response to therapy? ❑ **Yes** ❑ **No**

Does the patient have liver iron concentration (LIC) 3 mg Fe/g dw or higher? ❑ **Yes** ❑ **No**

Has the patient experienced a reduction from baseline in serum ferritin level or liver iron concentration (LIC)? ❑ **Yes** ❑ **No**

Exjade® Prior Authorization Request Form (Page 2 of 2)

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For myelodysplastic syndrome, answer the following:

Does the patient have low or intermediate-1 disease? ❑ **Yes** ❑ **No**

Is the patient a potential transplant patient? ❑ **Yes** ❑ **No**

Has the patient received more than 20 red blood cell transfusions? ❑ **Yes** ❑ **No**

Reauthorization:

Has the patient experienced a reduction from baseline in serum ferritin level or liver iron concentration (LIC)? ❑ **Yes** ❑ **No**

Select the medications the patient has a failure, contraindication, or intolerance to:

❑ Ferriprox

❑ Jadenu

❑ Jadenu Sprinkle

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: This request may be denied unless all required information is received.
If the patient is not able to meet the above standard prior authorization requirements, please call 1-800-711-4555.
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.