maryland physicians care
Medicaid with a Heart

PRIOR AUTHORIZATION REQUEST

CHELATING AGENTS

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll-free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please note that supporting clinical documentation is required for **ALL** PA requests. Pharmacy prior authorization reviews can be subject to trial with additional medications that are not listed within the criteria. The policies are subject to change based on COMAR requirements, MDH transmittals and updates to treatment guidelines.

1 Is the request for an INITIAL or a CONTINUATION of therapy?

[] Initial (If checked, go to 7)

[] Continuation (If checked, go to 2)

2 Is the patient currently receiving the requested medication? Yes No
[If no, skip to question 7.]

If you have any questions, call: 1-888-258-8250

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3	Has the patient been receiving medication samples of the requested medication? [If yes, skip to question 7.]	Yes	No
4	Does the patient have a previously approved prior authorization (PA) on file with the current plan? [Note: If the patient does NOT have a previously approved PA on file for the requested medication with the current plan, the renewal request will be considered under initial therapy.] [If no, skip to question 7.]	Yes	No
5	Has the patient been established on therapy for at least 3 months? [If no, skip to question 7.]	Yes	No
6	Has documentation been submitted to confirm that the patient has had a clinically significant response to therapy, as determined by the provider? [NOTE: Examples of response of therapy include reduction in serum ferritin levels, stable disease, and reduced organ iron load.] ACTION REQUIRED: Submit supporting documentation. [No further questions.]	Yes	No
7	What is the indication or diagnosis? [] Chronic iron overload due to blood transfusions (If checked, go to 8) [] Chronic iron overload in non-transfusion-dependent thalassemia syndromes (If checked, go to 19) [] Transfusional chronic iron overload with thalassemia syndromes (If checked, go to 30) [] Transfusional chronic iron overload with sickle cell disease or other anemias (If checked, go to 30) [] Other (If checked, no further questions)		
8	What drug is being requested? [] Deferasirox TABLETS (If checked, go to 12) [] Deferasirox GRANULES IN PACKET, Deferasirox TABLET DISPERSABLE (If checked, go to 9) [] Exjade TABLET DISPERSABLE, Jadenu TABLET, Jadenu GRANULES IN PACKET (If checked, go to 11) [] Ferriprox TABLET, Deferiprone TABLET (If checked, no further questions) [] Ferriprox SOLUTION, ORAL (If checked, no further questions)		
9	Does the patient have dysphagia or is unable to swallow capsules/tablets?	Yes	No

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	[If yes, skip to question 12.]		
10	Is the patient using a feeding tube to take medications? [If yes, skip to question 12.] [If no, no further questions.]	Yes	No
11	Has the patient had a trial and failure with generic products of the requested medication? [NOTE: Generic for Jadenu and Exjade is deferasirox.] [If no, no further questions.]	Yes	No
12	Is the patient greater than or equal to 2 years of age? [If no, no further questions.]	Yes	No
13	Is the patient receiving blood transfusions at regular intervals for a chronic condition? [NOTE: Examples of chronic conditions include thalassemia syndromes, myelodysplastic syndrome, chronic anemia, and sickle cell disease] [If no, no further questions.]	Yes	No
14	Has documentation been submitted to confirm that the patient has a serum ferritin level greater than 1,000 micrograms/liter (mcg/L) prior to starting chelating therapy? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
15	Does the prescriber agree to monitor the patient's blood counts, liver function, renal function, and ferritin levels monthly? [If no, no further questions.]	Yes	No
16	Does the patient have an estimated glomerular filtration rate (eGFR) greater than 40 mL/min/1.73 m2? [If no, no further questions.]	Yes	No
17	Is the requested medication being prescribed by, or in consultation with, a hematologist? [If no, no further questions.]	Yes	No
18	Does the requested dose exceed the Food and Drug Administration approved label dosing for the indication? [Dosing: Exjade: Initial: 20 mg/kg once daily; Jadenu: Initial: 14 mg/kg once daily.] [No further questions.]	Yes	No
19	What drug is being requested? [] Deferasirox TABLETS (If checked, go to 23) [] Deferasirox GRANULES IN PACKET, Deferasirox TABLET DISPERSABLE (If checked, go to 20)		

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	[] Exjade TABLET DISPERSABLE, Jadenu TABLET, Jadenu GRANULES IN PACKET (If checked, go to 22) [] Ferriprox TABLET, Deferiprone TABLET (If checked, no further questions) [] Ferriprox SOLUTION, ORAL (If checked, no further questions)		
20	Does the patient have dysphagia or is unable to swallow capsules/tablets? [If yes, skip to question 23.]	Yes	No
21	Is the patient using a feeding tube to take medications? [If yes, skip to question 23.] [If no, no further questions.]	Yes	No
22	Has the patient had a trial and failure with generic products of the requested medication? [NOTE: Generic for Jadenu and Exjade is deferasirox.] [If no, no further questions.]	Yes	No
23	Is the patient greater than or equal to 10 years of age? [If no, no further questions.]	Yes	No
24	Has documentation been submitted to confirm that the patient has a liver iron concentration (LIC) of at least 5 milligrams iron per gram of liver dry weight (mg Fe/g dw)? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
25	Has documentation been submitted to confirm that the patient has a serum ferritin level greater than 300 micrograms/liter (mcg/L) prior to starting chelating therapy? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
26	Does the provider attest that the patient's blood counts, liver function, renal function, and ferritin levels will be monitored monthly? [If no, no further questions.]	Yes	No
27	Does the patient have an estimated glomerular filtration rate (eGFR) greater than 40 mL/min/1.73 m2? [If no, no further questions.]	Yes	No
28	Is the requested medication being prescribed by, or in consultation with, a hematologist? [If no, no further questions.]	Yes	No
29	Does the requested dose exceed the Food and Drug Administration approved label dosing for the indication? [Dosing: Exjade Initial: 10 mg/kg once daily; after 4 weeks, if baseline hepatic iron concentration was greater than 15 mg Fe/g dry weight, may increase to 20 mg/kg	Yes	No

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	once daily.; Jadenu Initial: 7 mg/kg once daily; after 4 weeks, if hepatic iron concentration was greater than 15 mg Fe/g dry weight, may increase to 14 mg/kg once daily.] [No further questions.]		
30	What drug is being requested? [] Deferasirox, Exjade, Jadenu, Jadenu sprinkle (If checked, no further questions) [] Deferiprone TABLET (If checked, go to 35) [] Ferriprox ORAL SOLUTION (If checked, go to 31) [] Ferriprox TABLET (If checked, go to 34)		
31	Does the patient have dysphagia or is unable to swallow capsules/tablets? [If yes, skip to question 33.]	Yes	No
32	Is the patient using a feeding tube to take medications? [If no, no further questions.]	Yes	No
33	Is the patient greater than or equal to 3 years of age? [If yes, skip to question 36.] [If no, no further questions.]	Yes	No
34	Has the patient had a trial and failure with generic products of the requested medication? [NOTE: Generic for Ferriprox is deferiprone] [If no, no further questions.]	Yes	No
35	Is the patient greater than or equal to 8 years of age? [If no, no further questions.]	Yes	No
36	Has documentation been submitted to confirm that the patient has a serum ferritin level greater than 1,000 micrograms/liter (mcg/L) prior to starting chelating therapy? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
37	Has the patient's absolute neutrophil count (ANC) been measured before initiating therapy and will be measured weekly thereafter? [If no, no further questions.]	Yes	No
38	Does the provider attest that the patient's serum ferritin concentration levels will be measured every 2 to 3 months? [If no, no further questions.]	Yes	No
39	Is the requested medication being prescribed by, or in consultation with, a hematologist? [If no, no further questions.]	Yes	No

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40	Does the requested dose exceed the Food and Drug Administration approved label dosing for the indication? [Dosing: ADULTS: Three-times-daily dosing: Oral solution (100 mg/mL), 500 mg tablet, or three-times-daily 1,000 mg tablet formulation: Oral: 75 mg/kg/day in 3 divided doses; Two-times daily dosing: Twice-daily 1,000 mg tablet formulation: Oral: 75 mg/kg/day in 2 divided doses. PEDS: Oral solution: Oral: 25 mg/kg/dose 3 times daily; round dose to the nearest 250 mg; Twice-daily 1,000 mg tablet formulation: Oral: Initial: 37.5 mg/kg/dose every 12 hours; round dose to the nearest 500 mg; Three-times-daily dosing: Oral solution, 3-times-daily 500 mg or 1,000 mg tablet formulations: Oral: Initial: 25 mg/kg/dose 3 times daily.]	Yes	No

Please document the diagnoses, symptoms, and/or any other information important to this review:

SECTION B: Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 1-833-896-0656

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

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If you have any questions, call: 1-888-258-8250