

OPTIMA FAMILY CARE MEDALLION 4.0

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: *The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff; fax to 1-800-750-9692. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. Incomplete forms will delay the authorization process.*

Drug Requested (please check applicable box below):

<input type="checkbox"/> Exjade[®] (deferasirox)	<input type="checkbox"/> Jadenu[®] (deferasirox) (tablets, Sprinkles)
<input type="checkbox"/> Ferriprox[™] (deferiprone)	

DRUG INFORMATION: Complete all information below or authorization process will be delayed

Drug Name/Form: _____

Strength/Quantity per Day: _____

Dosing Schedule: _____ **Length of Therapy:** _____

Diagnosis: _____ **ICD Code, if applicable:** _____

CLINICAL CRITERIA: To receive a **SIX (6) month approval** for one of the drugs listed below, **ALL** appropriate boxes **must** be checked to qualify to ensure the authorization process will **NOT** be delayed.

For Ferriprox[®]:

- Is member using this for the treatment of transfusional iron overload due to thalassemia syndromes when current chelation therapy is inadequate? Yes No

For Exjade[™] / Jadenu[®]:

- Is member using this drug for the treatment of transfusional iron overload Yes No
- OR**
- Is member being treated for iron overload due to non-transfusion-dependent thalassemia syndromes? Yes No

Use of samples to initiate therapy **does not meet step-edit/preauthorization criteria.**

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****

Patient Name: _____

Member Optima #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____