OPTIMA HEALTH COMMUNITY CARE
AND
OPTIMA FAMILY CARE
(MEDICAID)

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):	
❑ **Exjade**® (deferasirox)	❑ **Jadenu**® (deferasirox) (tablets, Sprinkles)
❑ **Ferriprox**™ (deferiprone)	

DRUG INFORMATON: Complete 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 or authorization process will 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

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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 #: ____

REVISED/UPDATED: ~~12/23/2017;~~ **8/20/2018**