OPTIMA HEALTH COMMUNITY CARE

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 1-800-319-5003. 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. Authorization process will be delayed if incomplete.

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