OPTIMA HEALTH PLAN

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; **(Pharmacy) 1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: (Select drug below)

❑ **deferasirox** (Exjade®) **tablets for oral suspension**	❑ **deferasirox** (Jadenu®) **tablets**
❑ **deferasirox** (Jadenu® sprinkle) **packet**	

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

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

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

Quantity Limits:

Exjade®: Maximum of 40 mg/kg/day.

Jadenu®: Maximum of 28 mg/kg/day.

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

❑ **For diagnosis of transfusional iron overload (transfusional hemosiderosis), ALL of the following criteria must be met for initial 6 month approval:**

- ❑ Member is ≥ 2 years of age and has a diagnosis of transfusional hemosiderosis (ie, transfusion of ≥100 mL/kg of packed red blood cells, approximately 20 units for a 40kg patient)
- ❑ Member's serum ferritin levels are consistently >1,000mcg/L (submit serum ferritin labs done within the last 30 days)
- ❑ Member's liver iron concentration (LIC) is >5mg of Fe/g of dry weight (submit liver biopsy, MRI or other FDA-approved test to document LIC [Fe/g of dry weight])
- ❑ Member's current weight must be noted: _____
- ❑ Member has an eGFR ≥40mL/min/1.73m2 (submit renal function labs)
- ❑ Member's baseline liver function labs must be submitted (submit ALT, AST, bilirubin)
- ❑ If requesting brand Jadenu or Exjade, documentation of trial and intolerable life-endangering adverse event with generic deferasirox must be submitted

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❑ For diagnosis of non-transfusion-dependent thalassemia syndrome, **ALL** of the following criteria must be met **for initial 6 month approval**:

- ❑ Member is ≥10 years of age and has a diagnosis of non-transfusion-dependent thalassemia syndrome
- ❑ Liver iron concentration (LIC) is ≥5mg of Fe/g of dry weight (submit current liver biopsy, MRI or other FDA-approved test to document LIC)
- ❑ Serum ferritin is >300mcg/L (submit 2 serum ferritin labs, taken at least 1 month apart, from within the last 3 months)
- ❑ Member's current weight must be noted: _____
- ❑ Member has an eGFR ≥40mL/min/1.73m2 (submit renal function labs)
- ❑ Member's platelets levels are ≥50 x 109/L
- ❑ Member's baseline liver function labs must be submitted (submit ALT, AST, total bilirubin)
- ❑ If requesting brand Jadenu or Exjade, documentation of trial and intolerable life-endangering adverse event with generic deferasirox must be submitted

❑ **For 12 month reauthorization, ALL** of the following criteria must be met:

- ❑ Serum ferritin has decreased from baseline or last approval (submit current ferritin labs)
- ❑ Liver iron concentration (LIC) has decreased to < 5mg of Fe/g of dry weight or has been maintained at a level that is 30% lower than baseline level (submit liver biopsy, MRI or other FDA-approved test to document current LIC)
- ❑ If serum ferritin is <500 mcg/L or LIC is less than 3 mg Fe/g dw, deferasirox therapy will be temporarily discontinued; if <300 mcg/L, deferasirox therapy will be interrupted and LIC obtained
- ❑ Member's liver function continues to be monitored (submit current ALT, AST, bilirubin labs)
- ❑ Member's platelets levels are ≥50 x 109/L
- ❑ If requesting brand Jadenu or Exjade, documentation of trial and intolerable life-endangering adverse event with generic deferasirox must be submitted

Medication being provided by Specialty Pharmacy - PropriumRx

(Continued on next page; signature page is required to process request.)

(Please ensure signature page is attached to form.)

Not all drugs may be covered under every Plan

If a drug is non-formulary on a Plan, documentation of medical necessity will be required.

*****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 #: _____

***Approved by Pharmacy and Therapeutics Committee**: 11/19/2020
REVISED/UPDATED: 3/8/2021