BANK'S APOTHECARY
Specialty Pharmacy

FAX TO BANK'S APOTHECARY: 215-357-2129

HEALTH PARTNER PLANS
PRIOR AUTHORIZATION REQUEST FORM

DEFERASIROX – (Exjade® and Jadenu®) Renewal

Phone: 215-991-4300

Health Partners Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drugs, labs) left blank, illegible or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**
HPP Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Address:	NPI: Promise ID:
City, State ZIP:	*Prescriber PA PROMISe ID*:
Patient Primary Phone:	Address:
Line of Business: ☐ Medicaid	
☐ CHIP	City, State ZIP:
	Specialty/facility name (if applicable):

☐ Expedited/Urgent

Drug name:
Strength:
Days Supply:
Number of Refills:
Directions / SIG:

HPP's maximum approval time is 12 months but may be less depending on the drug.

Please attach any pertinent medical history including labs and information for this member that may support approval.

Please answer the following questions and sign.

Q1. Has the patient tolerated the medication without any side effects?

☐ Yes - Transfusional Iron Overload

☐ Yes – Chronic Iron Overload with Non-Transfusion Dependent Thalassemia Syndromes

☐ No

Q2.For transfusional iron overload, have the following lab results been attached? a. Serum ferritin level b. CBC with differential c. Serum creatinine and determine the creatinine clearance d. Serum transaminases and bilirubin e. Annual auditory and ophthalmic examinations if the patient has been taking deferasirox for one year or greater

☐ Yes ☐ No

Q3. For chronic iron overload with non-transfusion dependent thalassemia syndromes, have the following lab results been attached? a. Serum ferritin level b. CBC with differential c. Serum creatinine and determine the creatinine clearance d. Serum transaminases and bilirubin e. Annual auditory and ophthalmic examinations if the patient has been taking deferasirox for one year or greater

☐ Yes ☐ No

Q4. Has the dose of deferasirox been adjusted accordingly (please refer to individual PI)?

☐ Yes ☐ No

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Patient Name:	**Prescriber Name:**

Q5. Requested Duration:

☐ 6 Months

Q6. Additional Information:

Prescriber Signature

Date

Updated 2018

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