AmeriHealth Caritas
Iowa

# AmeriHealth Caritas Iowa Request for Prior Authorization

Deferasirox

Form applies to IA Health Link and ***hawk-i*** plans.

**Please print – accuracy is important.**

**Fax completed form to 1-855-825-2714. Provider Help Desk: 1-855-328-1612.**

| AmeriHealth Caritas Iowa member ID #: | | Patient name: | |
|---|---|---|---|
| Patient address: | | | DOB: |
| Provider NPI: | Prescriber name: | | Phone: |
| Prescriber address: | | | Fax: |
| Pharmacy name: | | | |
| Address: | | | Phone: |
| **Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.** | | | |
| Pharmacy NPI: | | Pharmacy fax: | NDC: |

Prior authorization is required for deferasirox. Requests will only be considered for FDA-approved dosing. Payment will be considered under the following conditions: 1) Patient does not have a serum creatinine greater than 2 times the age-appropriate upper limit of normal or creatinine clearance < 40mL/min; and 2) Patient does not have a poor performance status; and 3) Patient does not have a high-risk myelodysplastic syndrome; and 4) Patient does not have advanced malignancies; and 5) Patient does not have a platelet count < 50 x $10^9$/L.

Please note: AmeriHealth Caritas Iowa uses Iowa Medicaid Enterprise criteria. For complete criteria, please consult www.iowamedicaidpdl.com/pa_criteria.

Preferred: ☐ Exjade Non-Preferred: ☐ Jadenu

Dosage Instructions:

Strength: Quantity: Days Supply:

**Patient has a diagnosis of iron overload related to anemia:**

☐ Yes (attach documentation) ☐ No (provide diagnosis):

**Indicate member's current deferasirox treatment status:**

☐ Initial ☐ Continuation

**Patient's current weight in kg:** ____________ **Date obtained:** ____________

**Serum Creatinine greater than 2 times the age-appropriate upper limit of normal?**

☐ Yes ☐ No **Date obtained:** ____________

**Creatinine Clearance:** ____________ **Date obtained:** ____________

**Platelet Count:** ____________ **Date obtained:** ____________

**Serum Ferritin:** ____________ **Date obtained:** ____________
(attach labs dated within 30 days of request)

**Does patient have poor performance status?** ☐ Yes ☐ No

**Does patient have high-risk myelodysplastic syndrome?** ☐ Yes ☐ No

**Does patient have advanced malignancies?** ☐ Yes ☐ No

☐ **Transfusional Iron Overload (in addition to above):**

**Initiation of Therapy:** 1) Patient is 2 years of age or older; and 2) Patient has documentation of iron overload related to anemia (attach documentation); and 3) Patient has documentation of a recent history of frequent blood transfusions that has resulted in chronic iron overload; and 4) Serum ferritin is consistently > 1000 mcg/L (attach lab results dated within past month); and 5) Starting dose does not exceed: Exjade — 20mg/kg/day **or** Jadenu — 14mg/kg/day. Calculate dose to the nearest whole tablet. 6) Initial authorizations will be considered for up to 3 months. Continuation of therapy: 1) Serum ferritin has been measured within 30 days of continuation therapy request (attach lab results); and 2) Ferritin levels are > 500mcg/L and 3) Dose does not exceed: Exjade — 40mg/kg/day **or** Jadenu — 28mg/kg/day.

## Initial Requests:

**Patient has a recent history of frequent blood transfusions resulting in chronic iron overload?**

☐ Yes (provide recent transfusion dates) ☐ No

**Serum ferritin consistently > 1000 mcg/L:** ☐ Yes ☐ No

☐ **Non-Transfusional Iron Overload (in addition to above)**

**Initiation of therapy:** 1) Patient is 10 years of age or older; and 2) Patient has documentation of iron overload related to anemia (attach documentation); and 3) Serum ferritin and liver iron concentration (LIC) has been measured within 30 days of initiation (attach lab results); and 4) Serum ferritin levels are > 300mcg/L. 5) LIC are > 5mg Fe/g dw; and 6) Dose does not exceed: Exjade — 10mg/kg/day (if LIC is ≤ 15mg Fe/g dw), or 20mg/kg/day (if LIC is > 15mg Fe/g dw); **or** Jadenu — 7mg/kg/day (if LIC is ≤ 15mg Fe/g dw), or 14mg/kg/day (if LIC is > 15mg Fe/g dw). 7) Initial authorizations will be considered for up to 6 months. Continuation of Therapy: 1) Serum ferritin and LIC have been measured within 30 days of continuation therapy request; and 2) Serum ferritin levels are ≥ 300mcg/L; and 3) LIC is ≥ 3mg Fe/g dw; and 4) Dose does not exceed: Exjade — 10mg/kg/day (if LIC is 3 to 7 mg Fe/g dw), or 20mg/kg/day (if LIC is > 7mg Fe/g dw); **or** Jadenu — 7mg/kg/day (if LIC is 3 to 7 mg Fe/g dw) or 14mg/kg/day (if LIC is > 7mg Fe/g dw).

## Initial & Renewal Requests:

LIC: Date obtained: (attach labs dated within 30 days of request)

**Attach lab results and other documentation as necessary.**

| By signing this document, I attest that the information contained herein is true and accurate to the best of my knowledge and belief. By submitting this form, I acknowledge that I am submitting a request for authorization of health care services, and I agree to abide by and adhere to established federal and Iowa fraud, waste and abuse (FWA) rules and regulations and to remain in compliance with AmeriHealth Caritas Iowa's Program Integrity rules. I further acknowledge that any claim I submit is subject to investigations, review or audit as determined by AmeriHealth Caritas Iowa. I further acknowledge that an authorization is not a guarantee of payment. | |
|---|---|
| Prescriber signature:<br>(Must match prescriber listed above.) | Date of submission: |

Important note: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.

Check www.amerihealthcaritasia.com/Provider to confirm your version of this form.