



Prior Authorization Form

Exjade®

ONLY COMPLETED REQUESTS WILL BE REVIEWED

Drug Requested: [] Exjade®
Date: Patient ID#: DOB:
Patient Name: Provider NPI:
Prescribing Physician: Office Contact:
Office Fax #: Office Phone:

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1. DIAGNOSIS FOR DRUG REQUESTED:

- [] Chronic Iron overload due to blood transfusions
[] Other (specify)

2. PATIENT HISTORY:

a. Is the patient's serum ferritin level consistently greater than 1000mcg/L (as demonstrated with at least 2 lab values in the previous 2 months)? [] Yes [] No

Lab 1 Ref. Range Date
Lab 2 Ref. Range Date

Please add any other supporting medical information that may be useful in the decision-making process:

FAX TO (888) 671-5285. YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX OR MAIL.

Internal use only
Document #
Coverage effective date / /
Processor Initials Date
M F Rx coverage Y N STANDARD - SELECT LOB
Previous Auth Y N Approved Reviewer Initials Date