Independence Blue Cross

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: _____

ONLY COMPLETED REQUESTS WILL BE REVIEWED

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 **Coverage effective date / /**

Document #_____ Processor Initials_____ Date_____

M F Rx coverage Y N STANDARD - SELECT LOB_____

Previous Auth Y N **Approved** **Reviewer Initials**_____ Date_____