Prescriber Criteria Form

Deferasirox 2025 PA Fax 553-A v1 010125.docx
Exjade, Jadenu (deferasirox), Jadenu Sprinkle (deferasirox granules)
Coverage Determination

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673.** Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Deferasirox.

Drug Name (select from list of drugs shown):

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Does the patient have a diagnosis of chronic iron overload due to blood transfusions? [If no, then skip to question 3.]	Yes ◯	No ◯
2	Does the patient have a pretreatment serum ferritin level greater than 1000 micrograms per liter? [No further questions.]	Yes ◯	No ◯
3	Does the patient have a diagnosis of NON-transfusion-dependent thalassemia syndrome and chronic iron overload?	Yes ◯	No ◯

Comments: _____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.

Prescriber (or Authorized) Signature: _____ **Date:**_____