

**Exjade, Jadenu**  
**Prior Authorization Request**

**Send completed form to: Case Review Unit, CVS Caremark Prior Authorization Fax: 1-866-249-6155**

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-866-249-6155.** If you have questions regarding the prior authorization, please contact CVS Caremark at **1-866-814-5506**. For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

**Patient's Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
**Patient's ID:** \_\_\_\_\_ **Patient's Date of Birth:** \_\_\_\_\_  
**Physician's Name:** \_\_\_\_\_ **NPI#:** \_\_\_\_\_  
**Specialty:** \_\_\_\_\_ **Physician Office Telephone:** \_\_\_\_\_ **Physician Office Fax:** \_\_\_\_\_  
**Request Initiated For:** \_\_\_\_\_

1. Which drug is being prescribed?  Exjade  Jadenu  Other \_\_\_\_\_
2. What is the diagnosis?  
 Chronic iron overload due to blood transfusions  
 Chronic iron overload due to non-transfusion-dependent thalassemia syndromes  
 Other \_\_\_\_\_
3. What is the ICD-10 code? \_\_\_\_\_

***Complete the following question if patient has chronic iron overload due to blood transfusions***

4. What is the patient's **PRETREATMENT** serum ferritin level? \_\_\_\_\_ mcg/L  
*Note: If the patient is currently on therapy for iron overload, provide the patient's serum ferritin level before patient initiated therapy.*

***I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.***

**X** \_\_\_\_\_  
**Prescriber or Authorized Signature** **Date (mm/dd/yy)**

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Exjade, Jadenu SGM - 4/2017.

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