CVS caremark™ {{PANUMCODE}}

Exjade, Jadenu (deferasirox)

Prior Authorization Request

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.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

Patient's Name: {{MEMFIRST}} {{MEMLAST}} **Date**: {{TODAY}}
Patient's ID: {{MEMBERID}} **Patient's Date of Birth:** {{MEMBERDOB}}
Physician's Name: {{PHYFIRST}} {{PHYLAST}}
Specialty: _____, **NPI#:** _____
Physician Office Telephone: {{PHYSICIANPHONE}} **Physician Office Fax:** {{PHYSICIANFAX}}
Request Initiated For: {{DRUGNAME}}

ICD-10 Code: _____
Prescribed Drug and Dosage Form: _____
Is a loading dose required: ❑ Yes ❑ No
Prescribed Loading dose and duration: _____

Maintenance Dose and Frequency: _____

Section A: Preferred Product

1. Is the product being requested for the treatment of chronic iron overload?
   ❑ Yes ❑ No *If No, skip to next section.*

2. The preferred products for your patient's health plan are generic deferasirox, deferiprone, and deferoxamine. Can the patient's treatment be switched to a preferred product? ***If deferiprone or deferoxamine, please call 1-866-814-5506 to have the updated form faxed to your office OR you may complete the PA electronically (ePA). You may sign up online via CoverMyMeds at: www.covermymeds.com/epa/caremark/ or call 1-866-452-5017.***
   ❑ Yes - deferiprone ❑ Yes - deferoxamine ❑ Yes - deferasirox, *skip to next section*
   ❑ No - Continue request for Exjade or Jadenu
   ❑ Not applicable - Requested product is preferred, *skip to next section*

3. Does the patient have a documented inadequate response or intolerable adverse event to any of the preferred products (deferasirox, deferiprone, deferoxamine)?
   ACTION REQUIRED: If Yes, attach supporting chart note(s). *Indicate ALL that apply.*
   ❑ deferasirox: ❑ Inadequate response ❑ Intolerable adverse event
   ❑ deferiprone: ❑ Inadequate response ❑ Intolerable adverse event
   ❑ deferoxamine: ❑ Inadequate response ❑ Intolerable adverse event
   ❑ No - None of the above

4. Was the documented intolerable adverse event an expected adverse event attributed to the active ingredient as described in the prescribing information? ***ACTION REQUIRED: If No, attach supporting chart note(s).***
   ❑ Yes ❑ No

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 Exjade, Jadenu [deferasirox] ACSF SGM 5/2023.

5. Does the patient have any of the following documented clinical reasons to avoid preferred products?
   ACTION REQUIRED: If Yes, attach supporting chart note(s). ❑ Yes ❑ No
   ❑ Estimated glomerular filtration rate (GFR) less than 40 mL/min/1.73 m^2, *specify product:* _____
   ❑ Poor performance status, *specify product:* _____
   ❑ High-risk myelodysplastic syndrome, *specify product:* _____
   ❑ Advanced malignancy, *specify product:* _____
   ❑ Platelet count less than 50 x 10^9/L, *specify product:* _____
   ❑ Known hypersensitivity to deferasirox or any components of drug formulations, *specify product:* _____
   ❑ Severe (Child-Pugh C) hepatic impairment, *specify product:* _____
   ❑ Known hypersensitivity to deferiprone or to any of the excipients in the formulation, *specify product:* _____
   ❑ Severe renal disease, *specify product:* _____
   ❑ No - None of the above

Section B: All Requests

1. Is this a request for continuation of therapy with the requested drug? ❑ Yes ❑ No *If No, skip to #8*

2. What is the diagnosis?
   ❑ Chronic iron overload due to blood transfusions (transfusional iron overload), *continue to #3*
   ❑ Chronic iron overload due to a non-transfusion-dependent thalassemia syndrome, *skip to #5*
   ❑ Hereditary hemochromatosis, *skip to #7*
   ❑ Other _____

3. Is the patient experiencing benefit from therapy as evidenced by a decrease in serum ferritin levels as compared to pretreatment baseline? ***ACTION REQUIRED: If Yes, attach supporting laboratory report or chart notes with current serum ferritin level***. ❑ Yes ❑ No

4. Is the patient's serum ferritin level consistently below 500 mcg/L? ❑ Yes ❑ No *No further questions.*

5. Is the patient experiencing benefit from therapy as evidenced by a decrease in serum ferritin levels as compared to pretreatment baseline? ***ACTION REQUIRED: If Yes, attach supporting laboratory report or chart notes with current serum ferritin level.*** ❑ Yes ❑ No

6. Is the patient's serum ferritin level consistently below 300 mcg/L? ❑ Yes ❑ No *No further questions.*

7. Is the patient experiencing benefit from therapy as evidenced by a decrease in serum ferritin levels as compared to pretreatment baseline? ❑ Yes ❑ No *No further questions.*

8. If the diagnosis is:
   ❑ Chronic iron overload due to blood transfusions (transfusional iron overload), *continue to #9*
   ❑ Chronic iron overload due to a non-transfusion-dependent thalassemia syndrome, *skip to #13*
   ❑ Hereditary hemochromatosis, *skip to #18*
   ❑ Other _____, *no further questions*

9. Is the patient's pretreatment serum ferritin level consistently greater than 1000 mcg/L? ***ACTION REQUIRED: If Yes, attach supporting laboratory report or chart notes with pretreatment serum ferritin level.*** ❑ Yes ❑ No

10. Which product is being requested?
    ❑ deferasirox tablets for suspension or Exjade
    ❑ deferasirox tablets or Jadenu, *skip to #12*

11. Will the dose of deferasirox tablets for suspension or Exjade exceed 40 mg/kg per day?
    ❑ Yes ❑ No *No further questions.*

12. Will the dose of deferasirox tablets or Jadenu exceed 28 mg/kg per day? ❑ Yes ❑ No *No further questions.*

13. Is the patient's pretreatment serum ferritin level greater than 300 mcg/L? ***ACTION REQUIRED: Attach supporting laboratory report or chart notes with pretreatment serum ferritin level.*** ❑ Yes ❑ No

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14. Is the patient's pretreatment liver iron concentration (LIC) at least 5 milligrams of iron per gram of liver dry weight (mg Fe/g dw)? ***ACTION REQUIRED: Attach supporting laboratory report or chart notes with pretreatment liver iron concentration.*** ❑ Yes ❑ No

15. Which product is being requested?
    ❑ deferasirox tablets for suspension or Exjade
    ❑ deferasirox tablets or Jadenu, *skip to #17*

16. Will the dose of deferasirox tablets for suspension or Exjade exceed 20 mg/kg per day?
    ❑ Yes ❑ No *No further questions.*

17. Will the dose of deferasirox tablets or Jadenu exceed 28 mg/kg per day? ❑ Yes ❑ No *No further questions.*

18. Has the patient had an unsatisfactory response to phlebotomy? *If Yes, no further questions.* ❑ Yes ❑ No

19. Is phlebotomy not an option for the patient (e.g., poor venous access, poor candidate due to underlying medical conditions)? ❑ Yes ❑ No

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)**

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