Prior Authorization Form

Note: Please provide as much information as possible on this form. Missing data may cause processing delays for requested authorization(s). Attach additional sheets to this form if necessary.

Please fax the completed PA form and any additional informational sheets to Nirvanahealth at the following fax number: +1(866) 871-8565

Patient Information		Prescriber Information	
Patient Name:		Prescriber Name:	
Health Plan Name:		Prescriber Address:	
Patient Insurance Id:			
Patient Date of Birth:		Prescriber Phone:	( )
Patient Phone:		Prescriber Fax:	( )
		Prescriber Specialty:	
		Prescriber DEA:	
		Prescriber NPI:	

Medication & Medical Information	
Requested Drug(s) & Strength(s):	[ ] deferasirox 125 mg dispersible tablet [ ] deferasirox 180 mg oral granules in packet [ ] deferasirox 180 mg tablet [ ] deferasirox 250 mg dispersible tablet [ ] deferasirox 360 mg oral granules in packet [ ] deferasirox 360 mg tablet [ ] deferasirox 500 mg dispersible tablet [ ] deferasirox 90 mg oral granules in packet [ ] deferasirox 90 mg tablet
Requested Daily Quantity Limit – Amount:	
Requested Daily Quantity Limit – Days:	
Requested Quantity Limit Over Time – Amount:	
Requested Quantity Limit Over Time – Days:	
Requested Quantity Per Rx – Amount:	
Expected Length of Therapy:	
Directions:	
Diagnosis and Diagnosis Codes (ICD-10 Standard Codes):	
List drugs used previously to treat the same condition:	
Additional clinical information or history. Please include any relevant test results and/or medical record notes:	

Questionnaire

Q1: I, as the provider or designated representative of the provider, certify and attest that the information provided is complete and accurate and that, upon request, I shall provide any information to RxAdvance that RxAdvance determines is reasonably necessary to verify my responses. (Check only one that apply)

[ ] Yes

[ ] No

Q2: Is the member currently treated with this medication? (Check only one that apply)

[ ] Yes (please list start date of therapy (month/day/year)) _____ (*Required)

[ ] No

Q3: What is the member's diagnosis? (Check only one that apply)

[ ] Chronic iron overload due to blood transfusions (transfusional hemosiderosis)

[ ] Myelodysplastic Syndrome (MDS)

[ ] Chronic iron overload due to non-transfusion-dependent thalassemia (NTDT)

[ ] Other (please specify the member's diagnosis and provide clinical rationale for the request) _____(*Required)

Q4: Does the member have a liver iron concentration 3 mg Fe/g dw or higher? (Check only one that apply)

[ ] Yes (please specify the liver iron concentration) _____ (*Required)

[ ] No (please provide clinical rationale for the request) _____ (*Required)

Q5: Does the member have experienced a reduction from baseline in serum ferritin level or liver iron concentration (LIC)? (Check only one that apply)

[ ] Yes

[ ] No (please provide clinical rationale for the request) _____ (*Required)

Q6: Does the member have experienced a reduction from baseline in serum ferritin level or liver iron concentration (LIC)? (Check only one that apply)

[ ] Yes

[ ] No (please provide clinical rationale for the request) _____ (*Required)

Q7: What is the member's diagnosis? (Check only one that apply)

[ ] Chronic iron overload due to blood transfusions (transfusional hemosiderosis)

[ ] Myelodysplastic Syndrome (MDS)

[ ] Chronic iron overload due to non-transfusion-dependent thalassemia (NTDT)

[ ] Other (please specify the member's diagnosis and provide clinical rationale for the request) _____(*Required)

Q8: Is the member 2 year of age or older? (Check only one that apply)

[ ] Yes

[ ] No (please provide member's age and clinical rationale for the request) _____(*Required)

Q9: Does the member have a baseline ferritin level more than 1,000 mcg/L? (Check only one that apply)

[ ] Yes (please specify lab test, lab values and date of lab test) _____ (*Required)

[ ] No (please provide clinical rationale for the request) _____ (*Required)

Q10: Does the member required the transfusion of at least 100 mL/kg packed red blood cells? (Check only one that apply)

[ ] Yes

[ ] No (please provide clinical rationale for the request) _____ (*Required)

Q11: Member meet one of the following? (Check only one that apply)

[ ] Low-1 disease or Intermediate-1 disease

[ ] Potential transplant patient

[ ] Other (please provide clinical rationale for the request) _____ (*Required)

Q12: Has the member received more than twenty (20) red blood cell transfusions? (Check only one that apply)

[ ] Yes

[ ] No (please provide clinical rationale for the request) _____ (*Required)

Q13: Is the member 10 year of age or older? (Check only one that apply)

[ ] Yes

[ ] No (please provide member's age and clinical rationale for the request) _____(*Required)

Q14: Does the member have liver iron concentration (LIC) 5 milligrams of iron per gram of liver dry weight (mg Fe/g dw) or higher? (Check only one that apply)

[ ] Yes (please specify lab test, lab values and date of lab test) _____ (*Required)

[ ] No (please provide clinical rationale for the request) _____ (*Required)

Q15: Does the member have serum ferritin level greater than 300 mcg/L? (Check only one that apply)

[ ] Yes (please specify lab test, lab values and date of lab test) _____ (*Required)

[ ] No (please provide clinical rationale for the request) _____ (*Required)

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, Insurer, Medical Group or its designated representatives may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.	
Signature of Prescriber or Authorized Representative:	Date:
Print Authorized Representative Name:	