Jefferson Health Plans

PRIOR AUTHORIZATION REQUEST FORM
Individual and Family Plans

Deferiprone

Fax back to: (833) 605-4407
Phone: (215) 991-4300

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: □ Exchange - PA	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	**Specialty/facility name (if applicable):**

☐ REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:	
Strength:	
Directions / SIG:	

Please attach any pertinent medical history including labs and information for this member that may support approval.
Please answer the following questions and sign.

Q1. Is deferiprone prescribed by or in consultation with hematologist?

☐ Yes ☐ No

Q2. Does the member have documentation of transfusional iron overload due to thalassemia syndromes, sickle cell disease or other anemias?

☐ Yes ☐ No

Q3. Does the member have documentation of Absolute Neutrophil Count (ANC) greater than or equal to 1.5 x 1000000000 (10 to the ninth power) per liter?

☐ Yes ☐ No

Q4. Is the request for a formulary product?

☐ Yes ☐ No

Q5. Is there documentation of inadequate response, intolerance, or contraindication to formulary agents indicated for patient's diagnosis that would not be expected to occur with requested agent?

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Patient Name:	**Prescriber Name:**

☐ Yes	☐ No
Q6. Additional Information:	

Prescriber Signature _____ Date _____

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