



**MEDICAID / CHIP**  
**PHARMACY PRIOR AUTHORIZATION REQUEST FORM**

**Iron Chelating Agents**

Phone: 866-841-7659

Fax back to: 866-240-3712

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.**

Member Name:		Prescriber Name:	
Member ID Number:	Fax:	Phone:	
Date of Birth:	Office Contact:		
Member Phone Number:	NPI:	PA PROMISe ID:	
Address:	Address:		
City, State ZIP:	City, State ZIP:		
Line of Business: <input type="checkbox"/> Medicaid <input type="checkbox"/> CHIP	Specialty Pharmacy (if applicable):		
Drug Name:	Strength:		
Quantity:	Refills:		
Directions:			
Diagnosis Code:	Diagnosis:		
<i>Jefferson Health Plans' maximum approval time is 12 months but may be less depending on the criteria..</i>			

**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 this a request for initiation of therapy with the requested drug?

[If no, skip to question 10.]

Yes

No

Q2. Is the requested drug being used for a diagnosis that is indicated in the United States Food and Drug Administration (FDA)-approved package labeling or a medically accepted indication?

Yes

No

Q3. Is the patient age-appropriate for the requested drug according to Food and Drug Administration (FDA)-approved package labeling, nationally recognized compendia or peer-reviewed medical literature?

Yes

No

Q4. Are the prescribed dose and duration of therapy consistent with Food and Drug Administration (FDA)-approved package labeling, nationally recognized compendia or peer-reviewed medical literature?

Yes

No

Q5. Is the requested drug prescribed by or in consultation with a specialist (i.e. hematologist)?

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Member Name:	Prescriber Name:
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q6. Does the patient have a history of a contraindication to the requested drug?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q7. Has baseline lab testing been done as recommended in the Food and Drug Administration (FDA)-approved package labeling? Note: Please attach documentation.	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q8. Is this a request for a non-preferred iron chelating agent?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q9. Does the patient have documented therapeutic failure with or contraindication or intolerance to the preferred iron chelating agents approved or medically acceptable for the diagnosis? Note: Please attach documentation.	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q10. Has the patient demonstrated tolerability and a positive clinical response to the requested drug? Note: Please attach documentation.	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q11. Is the requested drug prescribed by or in consultation with a specialist (i.e. hematologist)?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q12. Are the prescribed dose and duration of therapy consistent with Food and Drug Administration (FDA)-approved package labeling, nationally recognized compendia or peer-reviewed medical literature?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q13. Has the patient received recent lab monitoring as recommended in the Food and Drug Administration (FDA)-approved package labeling? Note: Please attach results.	



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Member Name:	Prescriber Name:
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<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Q14. Is continuing treatment with the requested drug indicated based on recent lab results as recommended in the Food and Drug Administration (FDA)-approved package labeling?

<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Q15. Additional Information:

\_\_\_\_\_  
Prescriber Signature

\_\_\_\_\_  
Date

v2026-06