



Prior Authorization Form

Exjade®/Ferriprox®

ONLY COMPLETED REQUESTS WILL BE REVIEWED

Drug Requested: Exjade® Ferriprox®

Date: _____

Patient ID#: _____ DOB: _____

Patient Name: _____

Provider NPI: _____

Prescribing Physician: _____

Office Contact: _____

Office Fax #: _____

Office Phone: _____

ONLY COMPLETED REQUESTS WILL BE REVIEWED

1. DIAGNOSIS FOR DRUG REQUESTED:

- Chronic Iron overload due to blood transfusions
- Transfusional Iron overload due to thalassemia syndromes
- Other (specify) _____

2. PATIENT HISTORY:

a. Is the patient's serum ferritin level consistently greater than 1000mcg/L (as demonstrated with at least 2 lab values in the previous 2 months)? Yes No

Lab 1 _____ Ref. Range _____

Date _____

Lab 2 _____ Ref. Range _____

Date _____

b. Is current chelation therapy inadequate? Yes No

Please add any other supporting medical information that may be useful in the decision-making process:

**FAX: (888) 671-5285 or EMAIL: FSS_Standard_Medicare@catalystrx.com
YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX OR MAIL**