



**Deferasirox**

**Express Scripts  
Prior Authorization  
Phone 1-844-424-8886  
Fax 1-877-251-5896**

To start your Part D Coverage Determination request, you (or your representative or your doctor or other prescriber) should contact Express Scripts, Inc (ESI):

- You may Call ESI at 1-844-424-8886, 24 hours a day, 7 days a week, TTY users: 1-800-716-3231
- You may Fax your request to: 1-877-251-5896 (Attention: Medicare Reviews)
- You may also send your request via email to: [medicarepartdparequests@express-scripts.com](mailto:medicarepartdparequests@express-scripts.com)

Member's Last Name:	Member's First Name:
SCAN ID number:	Date of Birth:
Prescriber's Name:	Contact Person:
Office phone:	Office Fax:

Medication:	Diagnosis:
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**SECTION A** Please answer the following questions

1.  Yes  No Is the indication for the treatment of chronic iron overload in patients with non-transfusion-dependent thalassemia syndromes? *(If Yes, skip to question 3.)*
2.  Yes  No Is the indication for the treatment of chronic iron overload due to blood transfusions?
3.  Yes  No Does the patient have a platelet count less than 50 x 10(9)/L?
4.  Yes  No Does the patient have high-risk myelodysplastic syndromes (MDS)?
5.  Yes  No Does the patient have advanced malignancies?
6.  Yes  No Does the patient have a serum creatinine greater than 2 times the age-appropriate upper limit of normal or is the creatinine clearance less than 40 mL/min?
7.  Yes  No Does the member have severe hepatic impairment (Child-Pugh Class C)?
8.  Yes  No Is the prescription written or recommended by a Hematologist?
9.  Yes  No Will baseline serum ferritin level be performed prior to the initiation of deferasirox?

*Please document serum ferritin level:*

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10.  Yes  No Will baseline liver function tests (ALT, AST, bilirubin) be performed prior to the initiation of deferasirox?

*Please document baseline liver function tests (ALT, AST, bilirubin):*

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***Please document the symptoms and/or any other information important to this review:***

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**SECTION B**

Physician Signature

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PHYSICIAN SIGNATURE

\_\_\_\_\_  
DATE

**FAX COMPLETED FORM TO: 1-877-251-5896**

Our response time for prescription drug coverage standard requests is 72 hours. If you or your prescriber believe that waiting 72 hours for a standard decision could seriously harm your life, health, or ability to regain maximum function, you can ask for an expedited (fast) decision. If your prescriber indicates that waiting 72 hours could seriously harm your health, we will automatically give you a decision within 24 hours. If you do not obtain your prescriber's support for an expedited request, we will decide if your case requires a fast decision. You cannot request an expedited coverage determination if you are asking us to pay you back for a drug you already received. View our formulary and Prior Authorization criteria online at <http://www.villagehealthca.com>