



Date \_\_\_\_\_

Client \_\_\_\_\_

### PRIOR AUTHORIZATION CRITERIA- EXJADE® (deferasirox)

<i>M.D. Last Name:</i> _____	<i>M.D. First Name:</i> _____
<i>Physician Phone:</i> _____	<i>Physician Fax:</i> _____
<i>Patient</i> _____	<i>ID#</i> _____ <i>DOB</i> _____

**TO ENSURE PROMPT PROCESSING PLEASE COMPLETE ALL OF THE QUESTIONS.**

- Is the diagnosis Chronic Iron Overload due to blood transfusions? (if yes, skip to #3) Yes    No
- If no, what is the diagnosis? \_\_\_\_\_ ICD9 Code \_\_\_\_\_  
**NOTE: If Exjade is requested "Off-label" please attach a peer-reviewed study showing statistically-significant safety and efficacy data.**
- What is the patient's weight (circle lbs or Kg)? \_\_\_\_\_ LBS    KG
- What is the Serum ferritin Level (must be > 1000mcg/L) \_\_\_\_\_ mcg/L
- Patient Age (must be >2 years old) \_\_\_\_\_
- Strength \_\_\_\_\_ SIG: \_\_\_\_\_
- Quantity \_\_\_\_\_ Duration of Therapy: \_\_\_\_\_

Physician Signature or name of person providing answers \_\_\_\_\_

Physician Comments \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Send or Fax completed form to:  
**877-329-7279**

RESTAT  
P.O. BOX 758  
WEST BEND, WI 53095

QUESTIONS PLEASE CALL:  
**877-526-9906**