



Date \_\_\_\_\_

Client \_\_\_\_\_

### PRIOR AUTHORIZATION QUESTIONNAIRE - 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.**

1. Is the diagnosis Chronic Iron Overload due to blood transfusions? (if yes, skip to #3) Yes    No
  
2. 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.**
  
3. What is the patient's weight (circle lbs or Kg)? \_\_\_\_\_ LBS    KG
  
4. What is the Serum ferritin Level (must be > 1000mcg/L) \_\_\_\_\_ mcg/L
  
5. Patient Age (must be >2 years old) \_\_\_\_\_
  
6. Strength \_\_\_\_\_ SIG: \_\_\_\_\_
  
7. Quantity \_\_\_\_\_ Duration of Therapy: \_\_\_\_\_

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

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

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

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

RESTAT  
11900 W. Lake Park Dr.  
Milwaukee, WI 53224

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

[www.restat.com](http://www.restat.com)