



## Ferriprox [deferiprone] Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-866-249-6155.** If you have questions regarding the prior authorization, please contact CVS Caremark at **1-866-814-5506**. For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

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Patient's Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Patient's ID: \_\_\_\_\_ Patient's Date of Birth: \_\_\_\_\_  
Physician's Name: \_\_\_\_\_ NPI#: \_\_\_\_\_  
Specialty: \_\_\_\_\_ Physician Office Fax: \_\_\_\_\_  
Physician Office Telephone: \_\_\_\_\_  
Request Initiated For: \_\_\_\_\_

1. What is the prescribed drug?  Ferriprox  deferiprone
2. What is the diagnosis?  
 Transfusional iron overload due to a thalassemia syndrome  
 Transfusional iron overload due to sickle cell disease or other anemias  
 Hereditary hemochromatosis  
 Other \_\_\_\_\_
3. What is the ICD-10 code? \_\_\_\_\_

*Complete the following sections based on the prescribed product, if applicable.*

### Section A: Ferriprox (Brand) Requests

4. Is the product being requested for the treatment of chronic iron overload?  
 Yes  No *If No, skip to section B.*
5. The preferred products for your patient's health plan are generic deferasirox, deferiprone, and deferoxamine. Can the patient's treatment be switched to a preferred product? ***If deferasirox or deferoxamine, please call 1-866-814-5506 to have the updated form faxed to your office OR you may complete the PA electronically (ePA). You may sign up online via CoverMyMeds at: [www.covermymeds.com/epa/caremark/](http://www.covermymeds.com/epa/caremark/) or call 1-866-452-5017.***  
 Yes - generic deferasirox  
 Yes - deferoxamine  
 Yes - deferiprone, skip to section B  
 No - Continue request for Ferriprox
6. Has the patient experienced a documented intolerable adverse event to the preferred product deferiprone? ***ACTION REQUIRED: If Yes, attach supporting chart note(s).***  Yes  No
7. Was the documented intolerable adverse event an expected adverse event attributed to the active ingredient as described in the prescribing information? ***ACTION REQUIRED: If No, attach supporting chart note(s).***  
 Yes  No
8. Does the patient have a documented inadequate response or intolerable adverse event with deferasirox?

**Send completed form to: Case Review Unit, CVS Caremark Prior Authorization Fax: 1-866-249-6155**

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**ACTION REQUIRED: If Yes, attach supporting chart note(s) and skip to #10.**  Yes  No

9. Does the patient have any of the following documented clinical reasons to avoid deferasirox products?  
**ACTION REQUIRED: If Yes, attach supporting chart note(s).**
- Estimated glomerular filtration rate (GFR) less than 40 mL/min/1.73 m<sup>2</sup>
  - Poor performance status
  - High-risk myelodysplastic syndrome
  - Advanced malignancy
  - Platelet count less than 50 x 10<sup>9</sup>/L
  - Known hypersensitivity to deferasirox or any components of drug formulations
  - Severe (Child-Pugh C) hepatic impairment
  - None of the above
10. Does the patient have a documented inadequate response or intolerable adverse event with deferoxamine?  
**ACTION REQUIRED: If Yes, attach supporting chart note(s) and skip to section B.**  Yes  No
11. Does the patient have any of the following documented clinical reasons to avoid deferoxamine products? **ACTION REQUIRED: If Yes, attach supporting chart note(s).**
- Severe renal disease
  - Anuria
  - Known hypersensitivity to deferoxamine
  - None of the above

Section B: All Requests

12. Is this a request for continuation of therapy with the requested drug?  Yes  No *If No, skip to #16*
13. *If patient has diagnosis of Hereditary hemochromatosis*, is the patient experiencing benefit from therapy as evidenced by decreased serum ferritin levels as compared to pretreatment baseline?  
 Yes  No *No further questions*
14. Is the patient experiencing benefit from therapy as evidenced by a decrease in serum ferritin levels as compared to pretreatment baseline? **ACTION REQUIRED: If Yes, attach supporting laboratory report or chart notes with current serum ferritin level.**  Yes  No
15. Is the patient's serum ferritin level consistently below 500 mcg/L?  Yes  No *No further questions.*
16. Does the member have transfusional iron overload due to myelodysplastic syndrome or Diamond Blackfan anemia?  
 Yes  No
17. Is the patient's pretreatment serum ferritin level consistently greater than 1000 mcg/L? *Note: If the patient is currently on therapy for iron overload, provide the patient's serum ferritin level before patient initiated therapy.*  
**ACTION REQUIRED: If Yes, attach supporting laboratory report or chart notes with pretreatment serum ferritin level.**  Yes  No
18. Will the dose of the requested drug exceed 99 mg/kg per day?  Yes  No
19. Has the patient had an unsatisfactory response to phlebotomy? *If Yes, no further questions*  Yes  No
20. Is phlebotomy not an option for the patient (e.g., poor candidate due to underlying medical conditions)?  
 Yes  No

***I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.***

X

\_\_\_\_\_  
Prescriber or Authorized Signature

\_\_\_\_\_  
Date (mm/dd/yy)

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