

IRON CHELATION PRIOR AUTHORIZATION REQUEST PRESCRIBER FAX FORM

Only the prescriber may complete this form. This form is for prospective, concurrent, and retrospective reviews.

The following documentation is **REQUIRED**. Incomplete forms will be returned for additional information. For formulary information please visit www.myprime.com. Start saving time today by filling out this form electronically. Visit covermy meds.com to begin using this free service.

What is the priority level of this request?

- Standard review
- Expedited/Urgent review – prescriber certifies that waiting for a standard review could seriously harm the patient’s life, health or ability to regain maximum function

Today’s Date: _____

PATIENT AND INSURANCE INFORMATION

Date of Service (if differs from Today’s Date): _____

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
Patient Address:	City, State, Zip:	Patient Telephone:	
Member ID Number:	Group Number:		

PRESCRIBER/CLINIC INFORMATION

Prescriber Name:	Prescriber NPI#:	Specialty:	Contact Name:
Clinic Name:	Clinic Address:		
City, State, Zip:	Phone #:	Secure Fax #:	

PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST

Patient diagnosis:

- Chronic iron overload due to blood transfusions (transfusional hemosiderosis)
- Chronic iron overload due to a non-transfusion dependent thalassemia syndrome
- Transfusional iron overload with thalassemia syndromes
- Transfusional iron overload with sickle cell disease or other anemias
- Other (ICD code and description): _____

Medication Requested:	Strength:
Dosing Schedule:	Quantity per Month:

All requests:

- What is the patient’s weight? _____ (kg)
- Is the patient currently treated with the requested agent? Yes No
If yes, is the patient currently stable on the requested agent? **Please note, chart notes are required**..... Yes No
- Has the patient been diagnosed with stage four advanced, metastatic cancer and the requested agent is being used to treat the cancer? Yes No
- Has the patient been diagnosed with stage four advanced, metastatic cancer and the requested agent is being used to treat an associated condition related to stage four advanced metastatic cancer? **Please note, chart notes are required.** Yes No
- If yes to either of the previous two questions, is the use of the requested agent consistent with best practices for the treatment of stage four advanced, metastatic cancer, or an associated condition; supported by peer-reviewed, evidence-based literature; and approved by the United States Food and Drug Administration? Yes No
- Does the patient have an FDA labeled contraindication to the requested agent? Yes No
If yes, please specify FDA labeled contraindications: _____
- Is the prescriber a specialist in the area of the patient's diagnosis (e.g., hematologist), or has the prescriber consulted with a specialist in the area of the patient's diagnosis? Yes No

Please continue to the next page.

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8. Will the patient be using the requested agent in combination with another iron chelating agent targeted in this program (i.e., deferasirox, deferiprone, Exjade, Ferriprox, Jadenu)? Yes No

9. Is the patient's age within FDA labeling for the requested indication for the requested agent? Yes No
 If yes, please provide support for using the requested agent for the patient's age for the requested indication: _____

10. Please list all reasons for selecting the requested agent for the indicated diagnosis, strength, dosing schedule, and quantity over alternatives (e.g., compendia support, journal articles, contraindications, allergies, history of adverse drug reactions to alternatives, lower dose has been tried, information supporting dose over FDA max). **Please note, documentation may be required:** _____

For transfusional iron overload with sickle cell disease or other anemias requests:

11. Does the patient have myelodysplastic syndrome? Yes No
 12. Does the patient have Diamond Blackfan anemia?..... Yes No

For chronic iron overload due to a non-transfusion dependent thalassemia syndrome requests:

13. Is the patient's baseline (pretreatment) liver iron (FE) concentration (LIC) at least 5 mg FE/g of dry weight? Yes No
 If no, is the patient's serum ferritin greater than 300 mcg/L?..... Yes No
 If no, is there MRI confirmation of iron deposition? Yes No
 14. Has the patient been treated with a deferasirox agent within the past 90 days?..... Yes No
 If yes, is the LIC greater than 3 mg FE/g of dry weight?..... Yes No

For chronic iron overload due to blood transfusions (transfusional hemosiderosis) requests:

15. Is the patient's baseline (pretreatment) serum ferritin greater than 1,000 mcg/L? Yes No
 16. Has the patient been treated with a deferasirox agent within the past 90 days?..... Yes No
 If yes, is the patient's current (within the last 30 days) serum ferritin greater than 500 mcg/L?..... Yes No

For Ferriprox/deferiprone requests:

17. Does the patient have an absolute neutrophil count (ANC) greater than or equal to $1.5 \times 10^9/L$? Yes No

Please submit chart notes to support the answers to the following questions:

18. Has the patient tried and had an inadequate response to Exjade (deferasirox) or Jadenu (deferasirox)? Yes No
 19. Was Exjade (deferasirox) or Jadenu (deferasirox) discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? Yes No
 20. Does the patient have an intolerance or hypersensitivity to Exjade (deferasirox) or Jadenu (deferasirox)?..... Yes No
 21. Does the patient have an FDA labeled contraindication to BOTH Exjade (deferasirox) and Jadenu (deferasirox)? Yes No
 22. Is Exjade (deferasirox) or Jadenu (deferasirox) expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug; OR cause a significant barrier to the patient's adherence of care; OR worsen a comorbid condition; OR decrease the patient's ability to achieve or maintain reasonable functional ability in performing daily activities; OR cause an adverse reaction or cause physical or mental harm?..... Yes No
 23. Is Exjade (deferasirox) or Jadenu (deferasirox) not in the best interest of the patient based on medical necessity? Yes No
 24. Has the patient tried another prescription drug in the same pharmacologic class or with the same mechanism of action as Exjade (deferasirox) or Jadenu (deferasirox) and that prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? Yes No

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For brand Ferriprox requests:

Please submit chart notes to support the answers to the following questions:

25. Has the patient tried and had an inadequate response to a generic deferiprone? Yes No
26. Was generic deferiprone discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? Yes No
27. Does the patient have an intolerance or hypersensitivity to generic deferiprone? Yes No
28. Does the patient have an FDA labeled contraindication to generic deferiprone? Yes No
29. Is generic deferiprone expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug; OR cause a significant barrier to the patient's adherence of care; OR worsen a comorbid condition; OR decrease the patient's ability to achieve or maintain reasonable functional ability in performing daily activities; OR cause an adverse reaction or cause physical or mental harm? Yes No
30. Is the generic deferiprone agent not in the best interest of the patient based on medical necessity? Yes No
31. Has the patient tried another prescription drug in the same pharmacologic class or with the same mechanism of action as the generic equivalent and that prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? Yes No
32. Is there support for the use of the requested brand agent over the generic deferiprone? Yes No
 If yes, please provide supporting information: _____

For Exjade (deferasirox) or Jadenu (deferasirox) requests:

33. Does the patient have severe hepatic impairment (child-Pugh-Turcotte C)? Yes No

For Brand Exjade or Jadenu requests:

Brand	Generic Equivalent
Exjade (defarasirox) Jadenu (deferasirox)	Generic defarasirox

Please submit chart notes to support the answers to the following questions:

34. Has the patient tried and had an inadequate response to generic equivalent? Yes No
35. Was the generic equivalent discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? Yes No
36. Does the patient have an intolerance or hypersensitivity to the generic equivalent? Yes No
37. Does the patient have an FDA labeled contraindication to all generic equivalents? Yes No
38. Is the generic equivalent expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug; OR cause a significant barrier to the patient's adherence of care; OR worsen a comorbid condition; OR decrease the patient's ability to achieve or maintain reasonable functional ability in performing daily activities; OR cause an adverse reaction or cause physical or mental harm? Yes No
39. Is the generic equivalent agent not in the best interest of the patient based on medical necessity? Yes No
40. Has the patient tried another prescription drug in the same pharmacologic class or with the same mechanism of action as the generic equivalent and that prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? Yes No
41. Is there support for the use of the requested brand agent over the generic equivalent? Yes No
 If yes, please provide supporting information: _____

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For renewal requests:

42. Has the patient had clinical benefit with the requested agent? Yes No

For chronic iron overload due to blood transfusions (transfusional hemosiderosis) requests:

43. Has the patient had a decrease in serum ferritin from baseline (pretreatment)?..... Yes No

44. Is the patient's current serum ferritin greater than 500 mcg/L? Yes No

For non-transfusional iron overload due to thalassemia syndromes requests:

45. Is the patient's current serum ferritin greater than 300 mcg/L? Yes No

Please fax or mail this form to:

Prime Therapeutics LLC
 Clinical Review Department
 2900 Ames Crossing Road Suite 200
 Eagan, MN 55121

TOLL FREE

Phone:

Fax: 877.243.6930

BCBSIL: 800.285.9426

BCBSMT: 888.723.7443

BCBSNM: 800.544.1378

BCBSOK: 800.991.5643

BCBSTX: 800.289.1525

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