AvMed

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-305-671-0200**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: (Select drug below)

❑ **deferiprone** (Ferriprox®) **tablets**	❑ **Ferriprox®** (deferiprone) **solution**	❑ **Ferriprox® 2-day** (deferiprone) **tablets**

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member AvMed #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight (if applicable): _____ **Date weight obtained:** _____

Recommended Dosing Limits: Maximum 99 mg/kg/day (actual body weight) in two divided doses

CLINICAL CRITERIA: Check below all that apply. **All criteria must be met for approval**. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

Initial Authorization: 6 months

- ❑ Member is 3 years of age or older
- ❑ Member has a diagnosis of transfusional iron overload due to thalassemia syndrome, sickle cell disease or other anemia diagnosis (excluding myelodysplastic syndrome or Diamond Blackfan anemia) and has received no less than 20 transfusions of RBCs

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- ❑ Member's serum ferritin levels are consistently >1,000 mcg/L **(submit serum ferritin labs done within the last 30 days)**
- ❑ Medication will be dosed according to FDA recommendations for age, weight, serum ferritin levels and liver iron concentration
- ❑ Member is currently established on **ONE** of the following chelator therapies for at least 90 consecutive days **(verified by pharmacy paid claims)**:
  - ❑ deferoxamine (Desferal)
  - ❑ deferasirox (Exjade, Jadenu)
- ❑ Member continues to have **ONE** of the following after three (3) months of chelator therapy:
  - ❑ Serum ferritin in excess of 2,500 mcg/L **(submit current serum ferritin lab results)**
  - ❑ Liver iron concentration is >7 mg Fe/g dry weight **(submit liver biopsy, MRI or other FDA-approved test results)**
  - ❑ Cardiac magnetic resonance imaging (MRI T2*) is ≤ 10 ms **(submit MRI T2* lab results)**
  - ❑ Member has had trial and intolerable life-endangering adverse event with deferasirox (Exjade, Jadenu) or deferoxamine (Desferal) **(submit documentation of intolerance or adverse event)**
- ❑ Baseline absolute neutrophil count (ANC) is > 1.5×10^9/L and ANC will continue to be monitored weekly while on therapy **(submit current labs)**
- ❑ If requesting brand Ferriprox, documentation of trial and intolerable life-endangering adverse event with generic deferiprone must be submitted
- ❑ Ferriprox solution may be approved for members aged 3-10 years only. If requesting Ferriprox solution for members ≥ 11 years of age, documentation that member is unable to ingest any solid dosage form must be submitted

Reauthorization: 12 months. Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

- ❑ Member's ANC is > 1.5×10^9/L **(submit current lab results)**
- ❑ Member has had a clinically significant positive response to therapy, such as decrease in liver iron concentration, decrease in serum ferritin levels, or decrease in myocardial iron accumulation **(submit current LIC, serum ferritin, cardiac MRI or other test results)**
- ❑ Treatment will be withheld if serum ferritin falls consistently below 500 mcg/L

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Medication being provided by a Specialty Pharmacy – Proprium Rx

Not all drugs may be covered under every Plan
If a drug is non-formulary on a Plan, documentation of medical necessity will be required.
*****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.*****
****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****