# PRIOR AUTHORIZATION REQUEST

## Chelating Agents – Oral Iron Chelators

**Patient Information:**

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|---|---|
| Name: | |
| Member ID: | |
| Address: | |
| City, State, Zip: | |
| Date of Birth: | |

**Prescriber Information:**

| | |
|---|---|
| Name: | |
| NPI: | |
| Phone Number: | |
| Fax Number | |
| Address: | |
| City, State, Zip: | |

**Requested Medication**

| | |
|---|---|
| Rx Name: | |
| Rx Strength | |
| Rx Quantity: | |
| Rx Frequency: | |
| Rx Route of Administration: | |
| Diagnosis and ICD Code: | |

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll-free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please note that supporting clinical documentation is required for **ALL** PA requests. Pharmacy prior authorization reviews can be subject to trial with additional medications that are not listed within the criteria. The policies are subject to change based on COMAR requirements, MDH transmittals and updates to treatment guidelines.

| | | | |
|---|---|---|---|
| 1 | Is the medication being prescribed by or in consultation with hematologist?<br>[If no, no further questions.] | Yes | No |
| 2 | What drug is being requested?<br>[] Deferiprone (If checked, go to 9)<br><br>[] Ferriprox TABLET, Ferriprox (3 times a day) TABLET, Ferriprox (2 times a day) TABLET, MODIFIED RELEASE (If checked, go to 3) | | |

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[] Ferriprox SOLUTION, ORAL (If checked, go to 4)

[] Deferasirox GRANULES IN PACKET (EA) (If checked, go to 4)

[] Jadenu sprinkle GRANULES IN PACKET (EA) (If checked, go to 6)

[] Jadenu TABLET (If checked, go to 3)

[] Deferasirox TABLET (If checked, go to 9)

[] Exjade TABLET, DISPERSIBLE (If checked, go to 6)

[] Deferasirox TABLET, DISPERSIBLE (If checked, go to 4)

| | | | |
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| 3 | Has the patient had a trial and failure with generic products of the requested medication?<br>[NOTE: Generic for Ferriprox is deferiprone; Generic for Jadenu is deferasirox.]<br>[If no, no further questions.]<br>[If yes, skip to question 9.] | Yes | No |
| 4 | Does the patient have dysphagia or is unable to swallow capsules/tablets?<br>[If yes, skip to question 9.] | Yes | No |
| 5 | Is the patient using a feeding tube to take medications?<br>[If no, no further questions.]<br>[If yes, skip to question 9.] | Yes | No |
| 6 | Has the patient had a trial and failure with generic products of the requested medication?<br>[NOTE: Generic for Jadenu and Exjade is deferasirox.]<br>[If no, no further questions.] | Yes | No |
| 7 | Does the patient have dysphagia or is unable to swallow capsules/tablets?<br>[If yes, skip to question 9.] | Yes | No |
| 8 | Is the patient using a feeding tube to take medications?<br>[If no, no further questions.] | Yes | No |

9 What is the indication or diagnosis?

[] Chronic iron overload due to blood transfusions (If checked, go to 28)

[] Chronic iron overload in non-transfusion-dependent thalassemia syndromes (If checked, go to 18)

[] Transfusional chronic iron overload with thalassemia syndromes (If checked, go to 10)

[] Transfusional chronic iron overload with sickle cell disease or other anemias (If

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checked, go to 10)

[] Other (If checked, no further questions)

10 What drug is being requested?
[] Deferasirox, Exjade, Jadenu, Jadenu sprinkle (If checked, no further questions)

[] Ferriprox TABLET, Deferiprone TABLET (If checked, go to 11)

[] Ferriprox SOLUTION, ORAL (If checked, go to 12)

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| 11 | Is the patient greater than or equal to 8 years of age?<br>[If no, no further questions.]<br>[If yes, skip to question 13.] | Yes | No |
| 12 | Is the patient greater than or equal to 3 years of age?<br>[If no, no further questions.] | Yes | No |
| 13 | Is the request a continuation of therapy?<br>[If yes, skip to question 16.] | Yes | No |
| 14 | Has documentation been submitted to confirm that the patient has a serum ferritin level greater than 1,000 micrograms/liter (mcg/L) prior to starting chelating therapy? ACTION REQUIRED: Submit supporting documentation.<br>[If no, no further questions.] | Yes | No |
| 15 | Has the patient's Absolute neutrophil count (ANC) been measured before initiating therapy and will be measured weekly thereafter?<br>[No further questions.] | Yes | No |
| 16 | Is the patient's Absolute neutrophil count (ANC) measured weekly?<br>[If no, no further questions.] | Yes | No |
| 17 | Is the patient's serum ferritin concentration levels being measured every 2 to 3 months?<br>[If no, no further questions.]<br>[If yes, skip to question 34.] | Yes | No |

18 What drug is being requested?
[] Deferasirox, Exjade, Jadenu, Jadenu sprinkle (If checked, go to 22)

[] Deferiprone, Ferriprox (If checked, go to 19)

| | | | |
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| 19 | Is the request a continuation of therapy?<br>[If yes, skip to question 34.] | Yes | No |
| 20 | Does the patient have a documented diagnosis of thalassemia disorder?<br>[If no, no further questions.] | Yes | No |

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| 21 | Has documentation been submitted to confirm that the patient has a serum ferritin level greater than 300 micrograms/liter (mcg/L) prior to starting chelating therapy? ACTION REQUIRED: Submit supporting documentation.<br>[No further questions.] | Yes | No |
| 22 | Is the request a continuation of therapy?<br>[If yes, skip to question 26.] | Yes | No |
| 23 | Is the patient greater than or equal to 10 years of age?<br>[If no, no further questions.] | Yes | No |
| 24 | Has documentation been submitted to confirm that the patient has a liver iron concentration (LIC) of at least 5 milligrams iron per gram of liver dry weight (mg Fe/g dw)? ACTION REQUIRED: Submit supporting documentation.<br>[If no, no further questions.] | Yes | No |
| 25 | Has documentation been submitted to confirm that the patient has a serum ferritin level greater than 300 micrograms/liter (mcg/L) prior to starting chelating therapy? ACTION REQUIRED: Submit supporting documentation.<br>[If no, no further questions.]<br>[If yes, skip to question 33.] | Yes | No |
| 26 | Is the patient's blood counts, liver function, renal function, and ferritin levels being monitored monthly?<br>[If no, no further questions.] | Yes | No |
| 27 | Has documentation been submitted to confirm that the patient has a liver iron concentration (LIC) of at least 3 milligrams iron per gram of liver dry weight (mg Fe/g dw)? ACTION REQUIRED: Submit supporting documentation.<br>[If no, no further questions.]<br>[If yes, skip to question 34.] | Yes | No |
| 28 | Is the patient greater than or equal to 2 years of age?<br>[If no, no further questions.] | Yes | No |
| 29 | Does the prescriber agree to monitor the patient's blood counts, liver function, renal function, and ferritin levels monthly?<br>[If no, no further questions.] | Yes | No |
| 30 | Is the request a continuation of therapy?<br>[If yes, skip to question 34.] | Yes | No |
| 31 | Is the patient receiving blood transfusions at regular intervals for a chronic condition?<br>[NOTE: Examples of chronic conditions include thalassemia syndromes, myelodysplastic syndrome, chronic anemia, and sickle cell disease]<br>[If no, no further questions.] | Yes | No |

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| 32 | Has documentation been submitted to confirm that the patient has a serum ferritin level greater than 1,000 micrograms/liter (mcg/L) prior to starting chelating therapy? ACTION REQUIRED: Submit supporting documentation.<br>[If no, no further questions.] | Yes | No |
| 33 | Does the patient have an estimated glomerular filtration rate (eGFR) greater than 40 mL/min/1.73 m2?<br>[No further questions.] | Yes | No |
| 34 | Did the patient have a documented clinically significant response as determined by the prescriber?<br>[NOTE: Examples of response of therapy include reduction in serum ferritin levels, stable disease, and reduced organ iron load.] | Yes | No |

***Please document the diagnoses, symptoms, and/or any other information important to this review:***

SECTION B: Physician Signature

PHYSICIAN SIGNATURE DATE

## FAX COMPLETED FORM TO: 1-833-896-0656

**Disclaimer:** An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

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**If you have any questions, call: 1-888-258-8250**