Member Name: {{MEMFIRST}} {{MEMLAST}} **DOB:** {{MEMBERDOB}} **PA Number:** {{PANUMBER}}

CVS caremark™ {{PANUMCODE}}

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.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

Patient's Name: {{MEMFIRST}} {{MEMLAST}} **Date**: {{TODAY}}
Patient's ID: {{MEMBERID}} **Patient's Date of Birth:** {{MEMBERDOB}}
Physician's Name: {{PHYFIRST}} {{PHYLAST}}
Specialty: _____, **NPI#:** _____
Physician Office Telephone: {{PHYSICIANPHONE}} **Physician Office Fax:** {{PHYSICIANFAX}}
Request Initiated For: {{DRUGNAME}}

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
   ❑ 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 #12*

5. The preferred products for your patient's health plan are 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/ or call 1-866-452-5017.***
   ❑ Yes - deferasirox
   ❑ Yes - deferoxamine
   ❑ Yes - deferiprone, *skip to #12*
   ❑ 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? ***ACTION REQUIRED: If Yes, attach supporting chart note(s) and skip to #10.*** ❑ Yes ❑ No

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

 Ferriprox [deferiprone] ACSF SGM - 1/2022.

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^2
   - ❑ Poor performance status
   - ❑ High-risk myelodysplastic syndrome
   - ❑ Advanced malignancy
   - ❑ Platelet count less than 50 x 10^9/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 #12. ❑ 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 #15*

13. 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

14. Is the patient's serum ferritin level consistently below 500 mcg/L? ❑ Yes ❑ No *No further questions.*

15. Does the member have transfusional iron overload due to myelodysplastic syndrome or Diamond Blackfan anemia? ❑ Yes ❑ No

16. 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

17. Will the dose of the requested drug exceed 99 mg/kg per day? ❑ 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)**

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