PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Ferriprox (deferiprone)

Phone: 800-728-7947 Fax back to: 866-880-4532

The Scott & White Health Plan Pharmacy Department manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:	**Prescriber Name:** **Supervising Physician:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. What diagnosis is this drug being prescribed for? ☐ Transfusional iron overload due to thalassemia syndromes ☐ Other
Q2. Please indicate diagnosis and ICD code(s).
Q3. Is prescribing physician a hematologist or oncologist? ☐ Yes ☐ No
Q4. Is the patient a new start to therapy? ☐ Yes ☐ No (please provide start date)
Q5. Please specify the quantity and days supply being requested.
Q6. Please provide patient's current weight and requested dosing regimen.
Q7. Does the patient have a documented ANC > 1.5 x 109/L or > 1500/mm3?

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☐ Yes	☐ No
Q8. Does the patient have weekly ANC evaluation?	
☐ Yes	☐ No
Q9. Has patient experienced failure of an adequate trial of OR clinically significant intolerance, or contraindication(s) to any of the following? Please select all that apply. ☐ Exjade ☐ Deferoxamine ☐ Other (please specify) ☐ None of the above	
Q10. For continuation of therapy, does the patient have any of the following? Please specify all that apply. ☐ Serum ferritin > 500 mcg/L ☐ > or = 20% decline in serum ferritin within one year of starting therapy ☐ Weekly ANC evaluation ☐ None of the above	
Q11. Additional Comments	

Prescriber Signature

Date

□ Expedited/Urgent - By checking this box and signing above, I certify that applying the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function

Lack of the necessary documentation may result in a medical necessity denial. Requesting providers may speak to a SWHP pharmacist or medical director at 1-800-728-7947 regarding the case to have an opportunity to help impact the decision on a request before coverage

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has been decided.