OPTIMA HEALTH PLAN

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 1-800-750-9692**. 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 may be delayed.**

Drug Requested: (Select drug below)

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

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

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

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

Quantity 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. **Check the diagnosis below that applies.**

❑ **Diagnosis: Transfusional hemosiderosis due to thalassemia syndrome**

Initial Authorization: 6 months

- ❑ Member is 3 years of age or older
- ❑ Member has a diagnosis of transfusional hemosiderosis due to thalassemia syndrome (i.e., transfusion of ≥ 100 mL/kg of packed red blood cells, approximately 20 units for a 40 kg patient)
- ❑ Member's serum ferritin levels are consistently >1,000 mcg/L **(submit serum ferritin labs done within the last 30 days)**
- ❑ Member's current weight: _____
- ❑ 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
  - ❑ 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)**
- ❑ 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)**

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- ❑ 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

❑ **Diagnosis: Transfusional hemosiderosis due to thalassemia syndrome**

Reauthorization: 12 months.

- ❑ Member's ANC is > 1.5×10^9/L **(submit current lab results)**
- ❑ Liver iron concentration is ≤ 5 mg of Fe/g of dry weight **(submit current liver biopsy, MRI or other FDA-approved test results)**
- ❑ Treatment will be withheld if serum ferritin falls consistently below 500 mcg/L
- ❑ Serum ferritin has decreased by ≥ 20% from baseline or has been maintained at a level that is ≥ 20% below baseline level **(submit current serum ferritin labs)**

❑ **Diagnosis: Transfusional iron overload in members with sickle cell disease or other anemias**

Initial Authorization: 12 months

- ❑ Member is 3 years of age or older
- ❑ Member has a diagnosis of transfusional iron overload associated with sickle cell disease or other anemia diagnosis
- ❑ Baseline liver iron concentration > 7 mg of Fe/g dry weight **(submit current MRI results)**
- ❑ Member has received no less than 20 transfusions of RBCs
- ❑ 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)**

❑ **Diagnosis: Transfusional iron overload in members with sickle cell disease or other anemias**

Reauthorization: 12 months.

- ❑ Liver iron concentration has decreased by at least 4 mg of Fe/g dry weight from baseline or has been maintained at a level that is at least 4 mg of Fe/g dry weight below baseline level since last approval **(submit current MRI results)**
- ❑ Member's ANC is > 1.5×10^9/L **(submit current lab results)**
- ❑ Treatment will be withheld if serum ferritin falls consistently below 500 mcg/L

(Continued on next page; signature page is required to process request.)

(Please ensure signature page is attached to form.)

Medication being provided by a Specialty Pharmacy - PropriumRx

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.*

Member Name: _____

Member Optima #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

***Approved by Pharmacy and Therapeutics Committee**: 11/19/2020
REVISED/UPDATED: ~~3/8/2021; 11/12/2021; 12/23/2021; 2/7/2022;~~ **12/20/2022**