Desferal, deferoxamine

Prior Authorization Request

Your patient's benefit plan requires prior authorization for certain medications. In order to make appropriate medical necessity determinations, your patient's diagnosis and other clinical information is required. **Please complete the information requested on the form below and fax this form along with supporting clinical documentation to Priority Partners, toll-free at 1-866-212-4756 to initiate the review process.** If you have questions regarding the prior authorization please contact Priority Partners at 888-819-1043 Option 4**.**

Patient's Name: ______________________________ **Date**: ________________________________
Patient's ID: ______________________________ **Patient's Date of Birth:** ________________
Physician's Name: ____
Specialty: ______________________________ **NPI#:** ________________________________
Physician Office Telephone: __________________ **Physician Office Fax:** ___________________

<u>Referring</u> Provider Info: ❑ **Same as Requesting Provider**
Name: ____ **NPI#:** ______________________________
Fax: ________________________ **Phone:** _____________________

<u>Rendering</u> Provider Info: ❑ **Same as Referring Provider** ❑ **Same as Requesting Provider**
Name: ____ **NPI#:** ______________________________
Fax: ________________________ **Phone:** _____________________

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

<u>Required Demographic Information:</u>

Patient Weight: _________________________*kg*

*Patient Height:*_________________________*cm*

Please indicate the place of service for the requested drug:
❑ *Ambulatory Surgical* ❑ *Home* ❑ *Off Campus Outpatient Hospital*
❑ *On Campus Outpatient Hospital* ❑ *Office*

<u>Drug Information:</u>
*Strength/Measure*____________________________ *Units* ❑ ml ❑ Gm ❑ mg ❑ ea ❑ Un
*Directions(sig)*________________________________ *Route of administration*______________________
*Dosing frequency*_____________________________

Send completed form to: Priority Partners Fax: 1-866-212-4756

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Desferal, deferoxamine SGM 1620-A – 04/2023.

Criteria Questions:

1. Which drug is being prescribed?
   ❑ Desferal ❑ deferoxamine ❑ Other ____

2. What is the diagnosis?
   ❑ Chronic iron overload due to transfusion-dependent anemias
   ❑ Aluminum toxicity in a patient undergoing dialysis
   ❑ Hereditary hemochromatosis
   ❑ Other, please specify ____

3. What is the ICD-10 code? _____________

4. Is the patient currently receiving treatment with the requested medication? ❑ Yes ❑ No *If No, skip to diagnosis section*

5. *If the diagnosis is Chronic iron overload due to transfusion-dependent anemias,* 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 *No further questions*

6. *If the diagnosis is Aluminum toxicity in a patient undergoing dialysis,* is the patient experiencing benefit from therapy as evidenced by decreased serum aluminum concentrations and/or symptomatic improvement (e.g., neurological symptom improvement, decreased bone pain)? ❑ Yes ❑ No *No further questions*

7. *If the diagnosis is Hereditary Hemochromatosis,* is the patient experiencing benefit from therapy as evidenced by a decrease in serum ferritin levels as compared to pretreatment baseline?
   ❑ Yes ❑ No *No further questions*

Complete the following section based on the patient's diagnosis, if applicable.

Section A: Chronic Iron Overload Due to Transfusion-Dependent Anemias

8. Is the patient's pretreatment serum ferritin level consistently greater than 1000 mcg/L? ***ACTION REQUIRED: If Yes, attach supporting laboratory report or chart notes with pretreatment serum ferritin level.*** ❑ Yes ❑ No

Section B: Hereditary Hemochromatosis

9. Has the patient had an unsatisfactory response to phlebotomy? *If Yes, no further questions* ❑ Yes ❑ No

10. Is phlebotomy not an option for the patient (e.g., poor candidate due to underlying medical disorders)?
    ❑ 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)**

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