

Pharmacy Prior Authorization

AETNA BETTER HEALTH FLORIDA

Ferriprox

This fax machine is located in a secure location as required by HIPAA regulations.

Complete/review information, sign and date. Fax signed forms to Aetna Better Health Florida at **1-855-799-2554**.

When conditions are met, we will authorize the coverage of Ferriprox.

Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name

Ferriprox (deferiprone)

Other, please specify _____

Quantity _____ Frequency _____ Strength _____

Route of Administration _____ Expected Length of therapy _____

Patient Information

Patient Name: _____

Patient ID: _____

Patient Group No.: _____

Patient DOB: _____

Patient Phone: _____

Prescribing Physician

Physician Name: _____

Specialty: _____ NPI Number: _____

Physician Fax: _____ Physician Phone: _____

Physician Address: _____ City, State, Zip: _____

Diagnosis: _____ ICD Code: _____

Please circle the appropriate answer for each question.

- | | | |
|--|---|---|
| 1. Is the request for continuation of therapy?
[If yes, skip to question 6.] | Y | N |
| 2. Does the patient have a diagnosis of thalassemia per medical
records or "diagnosis code(s)"?
[If no, no further questions.] | Y | N |
| 3. Is the request for Ferriprox for any other diagnoses associated with
chronic anemia such as sickle cell anemia, aplastic anemia, etc.?
[If yes, no further questions.]] | Y | N |

- | | | |
|---|---|---|
| 4. Has documentation in medical records (e.g. progress notes, discharge notes) been submitted indicating failure of Exjade (after a minimum of 3 months of therapy) as demonstrated by serum ferritin consistently greater than 2500mcg/L, despite maximization of Exjade dosage at 40 mg/kg/day?
[If no, no further questions.] | Y | N |
| 5. Has a copy of the serum ferritin lab results been submitted?
[No further questions.] | Y | N |
| 6. Has a copy of serum ferritin results within 30 days of initiation of therapy been submitted?
[If no, no further questions.] | Y | N |
| 7. Are the ferritin levels greater than 500 mcg/L?
[If no, no further questions.] | Y | N |
| 8. Does the dose exceed 99 mg/kg/day? | Y | N |

Comments:

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature

Date