

Ferriprox (deferiprone) Prior Authorization Request Form



Caterpillar Prescription Drug Benefit Phone: 877-228-7909 Fax: 800-424-7640

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

				U	JRGENT
MEMBER INFORMATION					
LAST NAME:			FIRST NAME:		
PHONE NUMBER:			DATE OF BIRTH:	:	
STREET ADDRESS:					
CITY:			STATE:	ZIP CODE:	
PATIENT INSURANCE ID N	IUMBER:		l		
MALE FEMALE H	EIGHT (IN/CM):	WEIGH	НТ (LB/KG):	ALLERGIES:	
IF YOU ARE NOT THE PATIENT OR THE PRE FOLLOWING LINK: <u>HTTPS://MAGELLANRX</u>				RM WITH THIS REQUEST WHICH CAN BE FOUND AT THE OSURE AUTHORIZATION.PDF	į
PATIENT'S AUTHORIZED RI AUTHORIZED REPRESENTA	-	-			
PRESCRIBER INFORMATION	ON				
LAST NAME:			FIRST NAME:		
PRESCRIBER SPECIALTY:			EMAIL ADDRESS	S:	
NPI NUMBER:			DEA NUMBER:		
PHONE NUMBER:			FAX NUMBER:		
STREET ADDRESS:					
CITY:			STATE:	ZIP CODE:	
REQUESTOR (if different than prescriber):		OFFICE CONTACT PERSON:			
MEDICATION OR MEDICA	AL DISPENSING INFOR	RMATION			
MEDICATION NAME:					
DOSE/STRENGTH:	FREQUENCY:		LENGTH OF THERAPY/REFILL	QUANTITY: LS:	
NEW THERAPY DURATION OF THERAPY (S	RENEW SPECIFIC DATES):	/AL	IF RENEWAL: DA	ATE THERAPY INITIATED:	
Continued on next page.					

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MEMBER'S LAST NAME:	MEMBER'S FIRST NAME:					
1. HAS THE PATIENT TRIED ANY OTHER	R MEDICATIONS FOR THIS CONDITION?	YES (if yes, complete below) NO				
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE):	DURATION OF THERAPY (SPECIFY DATES):	RESPONSE/REASON FOR FAILURE/ALLERGY:				
2 LIST DIACNOSES:		ICD 10:				
2. LIST DIAGNOSES: □ Transfusional iron overload due to thalas: □ Transfusional iron overload due ton sick! □ Transfusional iron overload due to other: □ Other diagnosis:ICD-	le cell ranemias	ICD-10:				
3. REQUIRED CLINICAL INFORMATION: PRIOR AUTHORIZATION.	: PLEASE PROVIDE ALL RELEVANT CLINIC.	AL INFORMATION TO SUPPORT A				
Initial Request: Is the prescriber a hematologist or oncologist? Does patient have a serum ferritin less than 2,500 mcg/L? Yes No Please provide supporting chart notes. Has the patient tried and had an inadequate response or intolerance to deferoxamine? Yes No Please provide supporting chart notes. Does the patient have an absolute contraindication to deferoxamine therapy? Yes No Please provide supporting chart notes. Does patient have transfusional iron overload due to myelodysplastic syndrome or Diamond Blackfan anemia? Yes No Renewal Request: Is the prescriber a hematologist or oncologist? Does patient have a serum ferritin less than 2,500 mcg/L? Yes No Please provide supporting chart notes.						
Are there any other comments, diagnorphysician feels is important to this rev	oses, symptoms, medications tried or fa iew?	iled, and/or any other information the				
information is received.	e covered on all plans. This request may					
the Health Plan, insurer, Medical Group	n provided is true and accurate to the be o or its designees may perform a routine uracy of the information reported on thi	audit and request the medical				

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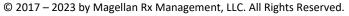
Prescriber Signature or Electronic I.D. Verification:	Date	·
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CONFIDENTIALITY NOTICE: The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately (via return FAX) and arrange for the return or destruction of these documents.

FAX THIS FORM TO: 800-424-7640

MAIL REQUESTS TO: Magellan Rx Management Prior Authorization Program

Attn: CP - 4201 P.O. Box 64811 St. Paul, MN 55164-0811



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