Fax completed form to: (855) 840-1678
If this is an URGENT request, please call (800) 882-4462 (800.88.CIGNA)

Exjade, Jadenu, Ferriprox

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician Name:			*Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed.*		
Specialty:	* DEA, NPI or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* Cigna ID:	* Date of Birth:	
Office Fax:			* Patient Street Address:		
Office Street Address:			City:	State:	Zip:
City:	State:	Zip:	Patient Phone:		

Urgency:
☐ Standard
☐ Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)

Medication requested:
☐ Exjade
☐ Jadenu
☐ Ferriprox
☐ deferiprone

ICD10:

Directions for use: Dose: Quantity: Duration of therapy:

Is the requested medication for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient? ☐ Yes ☐ No

Where will this medication be obtained?
☐ Accredo Specialty Pharmacy**
☐ Prescriber's office stock (billing on a medical claim form)
☐ Other (please specify):
☐ Retail pharmacy
☐ Home Health / Home Infusion vendor
***Cigna's nationally preferred specialty pharmacy*

***Medication orders can be placed with Accredo via E-prescribe - Accredo (1640 Century Center Pkwy, Memphis, TN 38134-8822 | NCPDP 4436920), Fax 888.302.1028, or Verbal 866.759.1557*

Facility and/or doctor dispensing and administering medication:
Facility Name: State: Tax ID#:
Address (City, State, Zip Code):

Diagnosis related to use:
☐ Treatment of transfusional iron overload due to Sickle Cell Disease
☐ Treatment of transfusional iron overload due to thalassemia syndromes
☐ Treatment of chronic iron overload with non-transfusion-dependent thalassemia (NTDT) syndromes
☐ Treatment of chronic iron overload due to blood transfusions (transfusional hemosiderosis)
☐ Other *(please specify)*:

Clinical Information:
Is this new start or continuation of therapy? ☐ new start ☐ continued therapy
(if continued therapy) Has your patient has demonstrated benefit from the iron chelation agent (for example: reduction in the serum ferritin levels, stable disease, reduced cardiac iron load)? ☐ Yes ☐ No

If Ferriprox or generic deferiprone:
Does your patient have a documented failure/inadequate response, contraindication per FDA label, intolerance, or is not a candidate for deferasirox? ☐ Yes ☐ No
(if thalassemia syndromes) Prior to starting Ferriprox therapy, was your patient's serum ferritin level documented at greater than 2,500 micrograms/liter (mcg/L)? ☐ Yes ☐ No
(if Sickle Cell) Prior to starting Ferriprox therapy, was your patient's serum ferritin level documented at greater than 1,000 micrograms/liter (mcg/L)? ☐ Yes ☐ No
(if NTDT) Prior to starting Ferriprox therapy, was your patient's serum ferritin level documented at greater than 300 micrograms/liter (mcg/L)? ☐ Yes ☐ No
Which drug is being requested?
☐ brand Ferriprox ☐ generic deferiprone

Is there documentation that your patient has tried the generic drug, deferiprone? ☐ Yes ☐ No

(if yes) Did your patient have an allergic or serious adverse reaction to this generic drug? ☐ Yes ☐ No

(if yes) Is there documentation that this was due to a formulation difference in the inactive ingredients between the brand and generic products (for example, difference in dyes, fillers, preservatives)? ☐ Yes ☐ No

Please explain.

If Exjade or Jadenu:

Does your patient have a documented intolerance or an inability to use deferasirox? ☐ Yes ☐ No

(if blood transfusions) Prior to starting Exjade or Jadenu (granules or tablets) therapy, was your patient's serum ferritin level documented at greater than 1,000 micrograms/liter (mcg/L)? ☐ Yes ☐ No

(if NTDT) Prior to starting Exjade or Jadenu (granules or tablets) therapy, was your patient's serum ferritin level documented at greater than 300 micrograms/liter (mcg/L)? ☐ Yes ☐ No

Additional Pertinent Information: *(including disease stage, prior therapy, performance status, and names/doses/admin schedule of any agents to be used concurrently):*

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature:____ **Date:**______________________

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Our standard response time for prescription drug coverage requests is 5 business days. If your request is urgent, it is important that you call us to expedite the request. View our Prescription Drug List and Coverage Policies online at cigna.com.

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