ALBERTA BLUE CROSS®

DEFERIPRONE
SPECIAL AUTHORIZATION REQUEST FORM

Please complete all required sections to allow your request to be processed.

Patients may or may not meet eligibility requirements as established by Alberta government sponsored drug programs.

PATIENT INFORMATION				**COVERAGE TYPE**
PATIENT LAST NAME	FIRST NAME		INITIAL	☐ Alberta Blue Cross ☐ Alberta Human Services ☐ Other
BIRTH DATE (YYYY-MM-DD)	ALBERTA PERSONAL HEALTH NUMBER			
STREET ADDRESS	CITY	PROV.	POSTAL CODE	ID, CLIENT OR COVERAGE NUMBER

PRESCRIBER INFORMATION

PRESCRIBER LAST NAME	FIRST NAME	INITIAL	PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION	
			☐ CPSA ☐ ACO ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other	REGISTRATION NUMBER
STREET ADDRESS				
CITY, PROVINCE			PHONE	FAX
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED	

Please provide the following information for NEW requests

Criteria for Coverage

"For the treatment of transfusional iron overload due to thalassemia syndromes in patients who require iron chelation therapy but who have an inadequate response to a sufficient trial (i.e. a minimum of 6 months) of deferoxamine, or for whom deferoxamine is contraindicated.

Contraindications to deferoxamine may include one or more of the following: known or suspected sensitivity to deferoxamine, recurrent injection or infusion-site reactions associated with deferoxamine administration (e.g., cellulitis), inability to obtain or maintain vascular access, severe needle phobia, concomitant bleeding disorders, immunocompromised patients with a risk of infection with parenteral administration, or risk of bleeding due to anticoagulation.

Special authorization may be granted for 6 months."

This product is eligible for auto-renewal.

Diagnosis

☐ Transfusional iron overload due to thalassemia syndromes
☐ Other (please specify) _____

Please indicate if **deferoxamine (e.g. Desferal)** was tried for **at least six months**

☐ Yes
☐ No; please indicate why deferoxamine was not tried for at least six months.
- ☐ Known or suspected sensitivity to deferoxamine
- ☐ Recurrent injection or infusion-site reactions associated with deferoxamine administration (e.g., cellulitis)
- ☐ Inability to obtain or maintain vascular access (please elaborate) _____
- ☐ Severe needle phobia
- ☐ Concomitant bleeding disorders (please specify) _____
- ☐ Immunocompromised with a risk of infection with parenteral administration
- ☐ Risk of bleeding due to anticoagulation
- ☐ Other (please specify) _____

Additional information relating to request

PRESCRIBER'S SIGNATURE	DATE	Please forward this request to
		▪ **Alberta Blue Cross, Clinical Drug Services** **10009 108 Street NW, Edmonton, Alberta T5J 3C5** ▪ **FAX**: **780-498-8384** in Edmonton • **1-877-828-4106** toll free all other areas

ONCE YOUR REQUEST HAS SUCCESSFULLY TRANSMITTED, PLEASE DO NOT MAIL OR RE-FAX YOUR REQUEST

The information on this form is being collected and pursuant to sections 20, 21 and 22 of the Health Information Act, and sections 33 and 34 of the Freedom of Information and Protection of Privacy Act, for the purposes of determining or verifying eligibility to participate in a program or receive a benefit, product or health service. If you have any questions regarding the collection or use of this information, please contact an Alberta Blue Cross privacy matters representative toll-free at 1-855-498-7302 or write to Privacy Matters, Alberta Blue Cross, 10009 - 108 Street, Edmonton AB T5J 3C5.

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