Physician Enrollment Form & Prescription

Please fax completed form to 1-800-269-5493

PATIENT INFORMATION

Patient First Name: _____ Patient Last Name: _____

Social Security No.: _____ - _____ - _____ Sex: ☐Male ☐Female Date of Birth _____ (mm /dd /yyyy)

Address: _____ City: _____ State: _____ Zip: _____

Primary Phone (Required): _____ Cell Phone: _____ Language: ☐ English ☐ Other _____

Please attach copies of patient insurance and prescription cards – front and back.

MEDICAL INFORMATION

Diagnosis: ☐ Transfusional Iron Overload E83.111

Due to: ☐ Beta Thalassemia 056.1 ☐Other Thalassemias 056.8 ☐Other _____

Height _____ inches or _____ cm Weight _____lb or _____kg Allergies: ☐None or Specify _____

Lab Test	Results	Date: mm/dd/yyyy
Most recent serum ferritin level (acceptable level <500 ng/ml)		___ /___ / _____

If available please provide the following	Results	Date: mm/dd/yyyy
Most recent liver iron concentration value (acceptable level <3,000 µg/g dry weight)		___ /___ / _____
Most recent cardiac MRI T2* value (acceptable level >20 ms)		

Prior Chelation Therapy _____ **Current Chelation Therapy** _____

Transfusion History

Approximate number of blood units/month	
Approximate interval between transfusions (weeks)	

DEFERIPRONE TABLETS 500 MG PRESCRIPTION/ORDER

☐Deferiprone tablets 500mg Number of Refills: _____

Standard dose is 75-99 mg/kg/day divided into 3 doses/day. **Dispense 30-day supply.**

PHYSICIAN/OFFICE INFORMATION

Prescriber's Name (print): _____ Office Contact Person: _____

Degree: ☐MD ☐DO ☐NP with prescribing authority Office Phone: _____

Specialty: _____ Office Fax: _____

Practice/Group Name: _____ Email: _____

Address: _____ Suite: _____ License No. _____ State Issued: _____

City: _____ City: _____ State: _____ Zip: _____

NPI No. _____ DEA No.:_____

By signing below, I certify that the therapy described above is medically necessary and that the information provided is accurate to the best of my knowledge. I also attest that I have obtained the patient's authorization to release the above information and such other personal information as may be necessary to the TaroCares Program and/or their agents. If the patient is 18 years old or younger, I attest that I have obtained permission from the patient's legal guardian.

Prescriber's Signature: _____ Date: ___ / ___ / _____

Please call 1-888-292-0744 if you have questions regarding this form, or contact TaroCares.
Please see Important Safety Information, including boxed WARNING, on the back.

Indication

Deferiprone is an iron chelator indicated for the treatment of patients with transfusional iron overload due to thalassemia syndromes when current chelation therapy is inadequate.

Approval is based on a reduction in serum ferritin levels. There are no controlled trials demonstrating a direct treatment benefit, such as improvement in disease-related symptoms, functioning, or increased survival.

Limitations of Use

Safety and effectiveness have not been established for the treatment of transfusional iron overload in patients with other chronic anemias.

Important Safety Information

WARNING: AGRANULOCYTOSIS AND NEUTROPENIA

- **Deferiprone can cause agranulocytosis that can lead to serious infections and death. Neutropenia may precede the development of agranulocytosis.**
- **Measure the absolute neutrophil count (ANC) before starting Deferiprone and monitor weekly while on therapy.**
- **Interrupt Deferiprone if infection develops and monitor the ANC more frequently.**
- **Advise patients taking Deferiprone to report immediately any symptoms indicative of infection.**

Deferiprone is contraindicated in patients with known hypersensitivity to deferiprone or to any of the excipients in the formulation.

In clinical studies, 7.5% of 642 patients treated with deferiprone developed increased ALT values. Four (0.62%) deferiprone-treated subjects discontinued the drug due to increased serum ALT levels and 1 (0.16%) due to an increase in both ALT and AST. Monitor serum ALT values monthly during therapy with Deferiprone and consider interruption of therapy if there is a persistent increase in the serum transaminase levels. Decreased plasma zinc concentrations have been observed on deferiprone therapy. Monitor plasma zinc, and supplement in the event of a deficiency.

Deferiprone can cause fetal harm. Advise females of reproductive potential to use an effective method of contraception during treatment with Deferiprone and for at least six months after the last dose. Advise males with female partners of reproductive potential to use effective contraception during treatment with Deferiprone and for at least three months after the last dose. Advise females not to breastfeed during treatment with Deferiprone and for at least 2 weeks after the last dose.

Avoid co-administration of Deferiprone with other drugs known to be associated with neutropenia or agranulocytosis; however, if this is unavoidable, closely monitor the absolute neutrophil count. Avoid co-administration with UGT1A6 inhibitors. Allow at least a 4-hour interval between administration of Deferiprone and drugs or supplements containing polyvalent cations (e.g., iron, aluminum, or zinc).

The most common adverse reactions are (incidence ≥ 5%) nausea, vomiting and abdominal pain, alanine aminotransferase increased, arthralgia, and neutropenia.

Inform patients that their urine might show a reddish/brown discoloration due to the excretion of iron. This is a very common sign of the desired effect, and it is not harmful.

Please see full Prescribing Information, including boxed WARNING and Medication Guide.

For more information, visit TaroCares.com. or tarousa.com

TARO CARES