# Authorization and Appeals Kit

## Navigating Patient Access to MIMRYLO™ (rusfertide)

This kit has been created as a reference with information and sample letters to help you communicate with health plans about prior authorization (PA) or appeal issues related to MIMRYLO.

## Table of Contents



Takeda Pharmaceuticals U.S.A., Inc. cannot guarantee insurance coverage or reimbursement. Coverage or reimbursement may vary significantly by payer, plan, patient, and setting of care. It is the sole responsibility of the healthcare provider to ensure the accuracy of all statements made in seeking coverage and reimbursement for an individual patient.

### INDICATION

MIMRYLO is indicated for the treatment of erythrocytosis in adults with polycythemia vera (PV).



Mimrylo™ rusfertide for injection

# Prior Authorization (PA) Checklist

When completing a PA, be sure to fill as much information on the form as possible. Incomplete information can lead to a PA denial.

Use the checklist below when filling out and submitting a PA form for MIMRYLO.

## Patient Information

- Use the health plan's website to locate their PA form
- Include the patient's information: name, DOB, sex, policy information
  - Patient's age should align with criteria (eg, patient is ≥18 years of age)

## Patient History

- Detailed history of inadequate HCT control
- List previous and/or current therapies or interventions, if applicable
  - Include dosage, frequency, duration (including dates), and impact, if any, on patient's symptoms
  - Explain why each therapy was discontinued, if applicable
- Document that all PA requirements of the plan have been met, if applicable

## Clinical Information

- Provide evidence that the patient is an appropriate candidate for MIMRYLO, for reasons including but not limited to:
  - Diagnosis of PV (including diagnosis code D45 for polycythemia vera)
  - Recent HCT levels
  - Recent thrombotic or CV event
  - Presence of symptoms such as but not limited to fatigue, pain, pruritus, insomnia, loss of concentration, night sweats, numbness/tingling in hands and feet, and gastrointestinal symptoms
- Additional information may include:
  - Clinical rationale based on efficacy and safety data for MIMRYLO
  - Adverse events or contraindications to other treatment options
  - Applicable treatment guidelines (NCCN Clinical Practice Guidelines in Oncology [NCCN Guidelines®])

Review the sample letter on the next page as a reference.

## Track the following throughout the submission process

- Dates and methods of correspondence
- Names of insurance contacts and reviewers
- Summaries of conversations and copies of written documents from insurer
- Reference numbers from phone conversations

## IMPORTANT SAFETY INFORMATION

### WARNINGS AND PRECAUTIONS

- **New or Worsening Thrombocytosis:** MIMRYLO may increase platelet counts in patients with PV. Platelet counts generally plateaued on treatment by Week 8. After initiating MIMRYLO and during dose modifications, monitor CBC every 2 to 4 weeks or as clinically indicated. Platelet elevations associated with MIMRYLO may require cytoreductive therapy initiation, modification, or MIMRYLO dose modifications or discontinuation.

CV, cardiovascular; DOB, date of birth; HCT, hematocrit; NCCN, National Comprehensive Cancer Network® (NCCN®); PV, polycythemia vera.



**Please see additional Important Safety Information on page 11 and full Prescribing Information.**

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# Sample PA Request Letter for MIMRYLO™ (rusfertide)

[Date]

[Prior Authorization Department/Medical Director]
[Name of Health Plan]
[Payer Mailing Address]
[City, State ZIP Code]

Re: [Patient First and Last Name]
[Date of Birth (MM/DD/YYYY)]
[Insurance ID Number]
[Case ID Number]

To whom it may concern:

I'm writing this letter on behalf of my patient, [Patient Name], to request coverage for MIMRYLO™ (rusfertide) for the treatment of erythrocytosis in patients with polycythemia vera (PV) (diagnosis code [insert code]).

[Patient Name] is [a/an] [age]-year-old [adult male/female] who was diagnosed with PV on [date of diagnosis]. [He/she] has been in my care since [date] and has previously tried and failed on other treatments including:

| Previous Therapy | Dose and Frequency | Duration of Therapy | Treatment Outcome and Reason for Discontinuation |
|---|---|---|---|
| [Name of Therapy] | [Dose and Frequency] | [Date Range] | [Reason for Discontinuation] |

[In addition, the following therapies are not appropriate for this patient:]

| Other Therapy | Reason for Intolerance or Inappropriate for Patient |
|---|---|
| [Name of Therapy] | [Reason for Intolerance or Inappropriateness. Reasons can include the following examples:<br>• Phlebotomy – severe coronary artery disease, advanced cardiovascular (CV) disease, or symptomatic hypertension<br>• Aspirin – high-risk gastrointestinal bleed, hypersensitivity, uncontrolled peptic ulcer disease, etc<br>• Hydroxyurea – intolerance or resistance, etc<br>• Peginterferon – autoimmune diagnosis, psychiatric illness, intolerance, decompensated liver diagnosis, etc<br>• Ruxolitinib – cytopenias, serious infections, lipid elevations, etc] |

[Patient Name] meets your MIMRYLO prior authorization criteria of:
- Diagnosis of PV
- [Erythrocytosis]
- Patient is 18 years of age or older
- [List out other applicable authorization criteria such as failure of previous therapies and/or contraindicated/intolerable therapies; recent thrombotic or CV event; presence of symptoms related to PV; hematocrit (HCT) ≥45%]

[This request aligns with treatment recommendations from the guidelines.]
[Provide a summary or the patient's medical history and current conditions and specific factors that led to the recommendation of MIMRYLO.] Attached are other relevant supporting documentation.

[If applicable, provide attestation that patient has tried and failed therapies (list therapies and reasons for discontinuation); attestation that patient has contraindications to other therapies (list out all therapies and reasons for contraindication or intolerance); attestation of presence of symptoms such as but not limited to fatigue, pain, pruritus, insomnia, loss of concentration, night sweats, numbness/tingling in hands and feet, and gastrointestinal symptoms; attestation of recent thrombotic/CV event; attestation of HCT ≥45%]

Please call my office at [phone number] for any questions or additional information you may require. I look forward to you timely approval.

Attached: [MIMRYLO Prescribing Information, clinical notes, medical records, other supporting documentation; applicable treatment guidelines]

Sincerely,

[Physician name printed]
[NPI number]
Phone: [Phone]
Fax: [Fax]
Address: [Street, City, State, Zip code]

[Physician signature]



**Please see Important Safety Information on page 11 and full Prescribing Information.**

Mimrylo™ rusfertide for injection

# Letter of Medical Necessity Checklist

When sending a letter of medical necessity be sure to include as much clarifying information within as possible. Incomplete information can lead to denial.

Use the checklist below when sending a letter of medical necessity for MIMRYLO.

### Patient Information

- Include the patient's information: name, DOB, sex, policy information

### Patient History

- List previous and/or current therapies, if applicable
  - Explain why each therapy was discontinued and give the duration of therapy for each agent
- Explain why formulary-preferred agents are not appropriate (if they have not already been listed as previous therapies)

### Clinical Information

- Include specific diagnosis code for PV where appropriate (D45 for polycythemia vera)
- Clearly state the rationale for treatment with MIMRYLO and why it is appropriate for your patient
- Be sure to attach all the listed documents to the letter when sending to your patient's insurance provider
- Provide rationale and clinical support for your recommendation. Information can include:
  - Efficacy and safety data for MIMRYLO
  - Adverse events or contraindications to other treatment options
  - Applicable treatment guidelines (NCCN Guidelines®)
- To close the letter, summarize your recommendation and provide a phone number should any additional information be required

Review the sample letter on the next page as a reference.

**Track the following throughout the submission process**

- Dates and methods of correspondence
- Names of insurance contacts and reviewers
- Summaries of conversations and copies of written documents from insurer
- Reference numbers from phone conversations

## IMPORTANT SAFETY INFORMATION (cont'd)

### WARNINGS AND PRECAUTIONS (cont'd)

- **Injection-Site Reactions:** Injection site reactions (including Grade 3 reactions) have been reported in patients treated with MIMRYLO. The most common injection site reactions reported were erythema, pruritus, pain, and swelling. Use ice, topical corticosteroid creams, antihistamines or analgesics, as needed, to treat injection site pain and swelling.



**Please see additional Important Safety Information on page 11 and full Prescribing Information.**

# Sample Letter of Medical Necessity for MIMRYLO™ (rusfertide)

[Date]

[Prior Authorization Department/Medical Director]
[Name of Health Plan]
[Payer Mailing Address]
[City, State ZIP Code]

Re: [Patient First and Last Name]
[Date of Birth (MM/DD/YYYY)]
[Insurance ID Number]
[Case ID Number]

To whom it may concern:

I am writing to provide additional information to support the medical necessity on behalf of [Patient Name]'s treatment of polycythemia vera (PV) with MIMRYLO™ (rusfertide). MIMRYLO is a peptide mimetic of hepcidin approved for the treatment of erythrocytosis in patients with PV. [If prior authorization has been submitted previously, please indicate date of submission and outcome]. Although I understand the reason for your denial is [insert reason for denial verbatim from plan's denial letter], I believe MIMRYLO [dose, frequency] subcutaneous injection is medically reasonable and necessary for [Patient Name]. This letter documents [Patient Name]'s diagnosis, and the appropriateness of MIMRYLO as a medically necessary treatment as prescribed. I would like to provide an overview of the patient's medical history, diagnosis, and treatment plan to support the medical need.

[Patient Name] is [a/an] [age]-year old adult [male/female] diagnosed with [diagnosis, including ICD-10 code D45]. [Patient Name] has been in my care since [date].

- The patient has PV as evidenced by [Insert summary of patient's condition, severity, and laboratory test results, such as age >60 and/or history of thrombosis, persistent hematocrit (HCT) levels >45% despite treatment]
- This patient has tried guideline-recommended therapies, including [treatment history]. [Insert duration of use and outcomes of past treatments]
- This patient also has [relevant medical history and other underlying health issues relevant to treatment selection]

Please see below for a list of treatments [Patient Name] has previously tried and failed:

| Previous Therapy | Dose and Frequency | Duration of Therapy | Treatment Outcome and Reason for Discontinuation |
|---|---|---|---|
| [Name of Therapy] | [Dose and Frequency] | [Date Range] | [Reason for Discontinuation] |

[In addition, the following therapies ae not appropriate for this patient:]

| Other Therapy | Reason for Intolerance or Inappropriate for Patient |
|---|---|
| [Name of Therapy] | [Reason for Intolerance or Inappropriateness. Reasons can include the following examples:<br>• Phlebotomy – severe coronary artery disease, advanced cardiovascular (CV) disease, or symptomatic hypertension<br>• Aspirin – high-risk gastrointestinal bleed, hypersensitivity, uncontrolled peptic ulcer disease, etc<br>• Hydroxyurea – intolerance or resistance, etc<br>• Peginterferon – autoimmune diagnosis, psychiatric illness, intolerance, decompensated liver diagnosis, etc<br>• Ruxolitinib – cytopenias, serious infections, lipid elevations, etc] |

[Patient continues to be symptomatic including X, Y, Z.]

[This request aligns with treatment recommendations from the guidelines.]

The attached records document [Patient Name]'s clinical condition and medical necessity for treatment with MIMRYLO.

[If applicable, provide attestation that patient has tried and failed therapies (list therapies and reasons for discontinuation); attestation that patient has contraindications to other therapies (list out all therapies and reasons for contraindication or intolerance); attestation of presence of symptoms such as but not limited to fatigue, pain, pruritus, insomnia, loss of concentration, night sweats, numbness/tingling in hands and feet, and gastrointestinal symptoms; attestation of recent thrombotic/CV event; attestation of HCT ≥45%]

Based on the above facts, I am confident that MIMRYLO is indicated and medically necessary for this patient. Please consider coverage of MIMRYLO and approve the use and subsequent payments as planned. Please refer to the attached Prescribing Information for MIMRYLO as needed and appropriate treatment guidelines. If you have any questions regarding this matter or need additional information, please do not hesitate to call me at [office number]. Thank you for your attention and I look forward to your timely response and approval of this claim.

Sincerely,

[Physician name printed]
[NPI number]
Phone: [Phone]
Fax: [Fax]
Address: [Street, City, State, Zip code]

[Physician signature]

**Please see Important Safety Information on page 11 and full Prescribing Information.**

# Letter of Appeal Checklist

When sending a letter of appeal be sure to include as much clarifying information within as possible. Incomplete information can lead to denial.

Use the checklist below when sending a letter of appeal for MIMRYLO.

### Patient Information

- Include the patient's information: name, DOB, sex, policy information
- Acknowledge that you are familiar with the company's policy and state the reason(s) for the denial

### Patient History

- List previous therapy/therapies, if applicable
  - Explain why each therapy was discontinued and give the duration of therapy for each agent
- If other agents/treatments are not appropriate for this patient, explain why not (if they have not already been listed as previous therapies)

### Clinical Information

- Document that all PA requirements of the plan have been met, if applicable
  - Diagnosis of PV (including diagnosis code D45 for polycythemia vera)
  - Patient is ≥18 years of age
- Provide rationale and clinical support for your recommendation. Information can include:
  - Efficacy and safety data for MIMRYLO
  - Adverse events or contraindications to other treatment options
  - Applicable treatment guidelines (NCCN Guidelines)
- Attach a Letter of Medical Necessity (see pages 4 and 5)

### Additional Information

For second- and third-level appeals, it may be helpful to include:

- The original letter of denial
- Specific medical notes in response to the denial
  - A third-level appeal may include a review by an independent noninsurance-affiliated external review board or hearing

Review the sample letter on the next page as a reference.

**Track the following throughout the submission process**

- Dates and methods of correspondence
- Names of insurance contacts and reviewers
- Summaries of conversations and copies of written documents from insurer
- Reference numbers from phone conversations

## IMPORTANT SAFETY INFORMATION (cont'd)

### WARNINGS AND PRECAUTIONS (cont'd)

- **Embryo-Fetal Toxicity:** Based on findings from animal reproduction studies, MIMRYLO may cause fetal harm when administered to a pregnant woman. Advise patients to stop taking MIMRYLO if they become pregnant.



**Please see additional Important Safety Information on page 11 and full Prescribing Information.**

Mimrylo™ rusfertide for injection

# Sample Letter of Appeal for MIMRYLO™ (rusfertide)

[Date]

[Prior Authorization Department/Medical Director]
[Name of Health Plan]
[Payer Mailing Address]
[City, State ZIP Code]

Re: [Patient First and Last Name]
[Date of Birth (MM/DD/YYYY)]
[Insurance ID Number]
[Case ID Number]

To whom it may concern:

| Reference Number | Therapy | Submission Date | Denial Date |
|---|---|---|---|
| [Reference Number] | MIMRYLO™ | [Submission Date] | [Denial Date] |

I am writing to request [reconsideration/appeal] for my patient [Patient Name] for the coverage of MIMRYLO™ (rusfertide) for the treatment of erythrocytosis in patients with polycythemia vera (PV). I have read and acknowledged your denial letter from [month day, year], and that MIMRYLO was denied because [insert reason from denial letter verbatim].

Based on this patient's condition and medical history, I believe treatment with MIMRYLO is warranted and appropriate. Please see my clinical reasonings below.

**Patient diagnosis and medical history to support the appeal:**

[Patient Name] is [a/an] [age]-year old adult [male/female] diagnosed with PV ([insert appropriate ICD-10-CM code here]) as of [date of diagnosis]. [He/she] has been in my care since [date].

[He/She] has a history of inadequate hematocrit (HCT) control and their HCT remains ≥45% as of [date].

[He/She] has previously been on the following therapies:

| Previous Therapy | Dose and Frequency | Duration of Therapy | Treatment Outcome and Reason for Discontinuation |
|---|---|---|---|
| [Name of Therapy] | [Dose and Frequency] | [Date Range] | [Reason for Discontinuation] |

[In addition, the following therapies are not appropriate for this patient:]

| Other Therapy | Reason for Intolerance or Inappropriate for Patient |
|---|---|
| [Name of Therapy] | [Reason for Intolerance or Inappropriateness. Reasons can include the following examples:<br>• Phlebotomy – severe coronary artery disease, advanced cardiovascular (CV) disease, or symptomatic hypertension<br>• Aspirin – high-risk gastrointestinal bleed, hypersensitivity, uncontrolled peptic ulcer disease, etc<br>• Hydroxyurea – intolerance or resistance, etc<br>• Peginterferon – autoimmune diagnosis, psychiatric illness, intolerance, decompensated liver diagnosis, etc<br>• Ruxolitinib – cytopenias, serious infections, lipid elevations, etc] |

[Patient continues to be symptomatic including X, Y, Z.]

[This request aligns with treatment recommendations from the guidelines.]

[Patient experienced a recent thrombotic/CV event.]

MIMRYLO is a peptide mimetic of hepcidin indicated for the treatment of erythrocytosis in adults with PV. Please see the attached Prescribing Information and Important Safety Information for the appropriateness of MIMRYLO.

Given my patient's medical history and lack of response to other medications, I strongly believe that use of MIMRYLO is medically necessary and appropriate for [Patient Name]. Please see attached for my patient's medical history and additional documentation that helps supports the need for treatment with MIMRYLO.

I appreciate your prompt review and ask that a reconsideration of the denial be made in the best interest of my patient. Please call me or my office staff at [phone number] if there are further questions or the need for additional information. I look forward to your timely response and approval of MIMRYLO for [Patient Name].

Sincerely,

[Physician name printed]
[NPI number]
Phone: [Phone]
Fax: [Fax]
Address: [Street, City, State, Zip code]

[Physician signature]

**Please see Important Safety Information on page 11 and full Prescribing Information.**

# Formulary Exception Request Letter Checklist

When sending a formulary exception request letter be sure to include as much clarifying information within as possible. Incomplete information can lead to denial.

Use the checklist below when sending a formulary exception request letter for MIMRYLO.

### Patient Information

- Include the patient's information: name, DOB, sex, policy information
- Note that the purpose of this letter is the patient is requesting an exception to the formulary to fill their prescription for MIMRYLO

### Patient History

- List previous therapy/therapies
  - If applicable, explain why each therapy was discontinued and give the duration of therapy for each agent
- If other agents/treatments are not appropriate for this patient, explain why not (if they have not already been listed as previous therapies)

### Clinical Information

- Include diagnosis and specific diagnosis code for PV where appropriate (D45 for polycythemia vera)
- Provide rationale and clinical support for your reason(s) for requesting this formulary exception
- Provide a phone number should additional information be required to answer any questions or to participate in a peer-to-peer review discussing the necessity of providing a formulary exception for the use of MIMRYLO for this patient

### Additional Information

- Include physician signature at the bottom of the letter
- If this is a second- or third-level appeal for formulary exception, include level of appeal, letter of denial, and medical notes in response to denial

Review the sample letter on the next page as a reference.

**Track the following throughout the submission process**

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- Names of insurance contacts and reviewers
- Summaries of conversations and copies of written documents from insurer
- Reference numbers from phone conversations

## IMPORTANT SAFETY INFORMATION (cont'd)

### ADVERSE REACTIONS

The most common (>15%) adverse reactions were injection site reactions (56%) and anemia (16%).



**Please see additional Important Safety Information on page 11 and full Prescribing Information.**

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# Sample Formulary Exception Request Letter for MIMRYLO™ (rusfertide)

[Date]

[Prior Authorization Department/Medical Director]
[Name of Health Plan]
[Payer Mailing Address]
[City, State ZIP Code]

Re: [Patient First and Last Name]
[Date of Birth (MM/DD/YYYY)]
[Insurance ID Number]
[Case ID Number]

To whom it may concern:

I am writing to request a formulary exception for MIMRYLO™ (rusfertide) for the treatment of erythrocytosis in patients with polycythemia vera (PV) on behalf of my patient [Patient Name], who is currently a member of [name of health plan].

Enclosed are additional information and documentation to support my decision to treat my patient with MIMRYLO. Based on the provided medical history, prognosis, and my clinical rationale, I am requesting a formulary exception so MIMRYLO is available to [Patient Name] as an approved medication.

**Patient diagnosis and medical history:**

[Patient Name] is [a/an] [age]-year old adult [male/female] diagnosed with polycythemia vera (PV) ([insert appropriate ICD-10-CM code here]) as of [date of diagnosis]. [He/she] has been in my care since [date].

[He/she] has previously been on the following therapies:

| Previous Therapy | Dose and Frequency | Duration of Therapy | Treatment Outcome and Reason for Discontinuation |
|---|---|---|---|
| [Name of Therapy] | [Dose and Frequency] | [Date Range] | [Reason for Discontinuation] |

[In addition, the following therapies are not appropriate for this patient:]

| Other Therapy | Reason for Intolerance or Inappropriate for Patient |
|---|---|
| [Name of Therapy] | [Reason for Intolerance or Inappropriateness. Reasons can include the following examples:<br>• Phlebotomy – severe coronary artery disease, advanced cardiovascular (CV) disease, or symptomatic hypertension<br>• Aspirin – high-risk gastrointestinal bleed, hypersensitivity, uncontrolled peptic ulcer disease, etc<br>• Hydroxyurea – intolerance or resistance, etc<br>• Peginterferon – autoimmune diagnosis, psychiatric illness, intolerance, decompensated liver diagnosis, etc<br>• Ruxolitinib – cytopenias, serious infections, lipid elevations, etc] |

[Provide a summary or the patient's medical history and current conditions and specific factors that led to the recommendation of MIMRYLO.] Attached are other relevant supporting documentation.

[If applicable, provide attestation that patient has tried and failed therapies (list therapies and reasons for discontinuation); attestation that patient has contraindications to other therapies (list out all therapies and reasons for contraindication or intolerance); attestation of presence of symptoms such as but not limited to fatigue, pain, pruritus, insomnia, loss of concentration, night sweats, numbness/tingling in hands and feet, and gastrointestinal symptoms; attestation of recent thrombotic/CV event; attestation of hematocrit (HCT) ≥45%]

**Treatment Rationale**

Given my patient's medical history, current prognosis and condition, [lack of response to other medications,] [and intolerance to other therapies,] I strongly believe that MIMRYLO is appropriate and medically necessary for [Patient Name], and adequate coverage should be approved.

I appreciate your prompt review and ask that any NDC blocks be removed, and a formulary exception be made in the best interest of my patient. Please call me or my office staff at [phone number] if there are further questions or the need for additional information. I look forward to your timely response and approval of MIMRYLO for [Patient Name].

Sincerely,

[Physician name printed]
[NPI number]
Phone: [Phone]
Fax: [Fax]
Address: [Street, City, State, Zip code]

[Physician signature]

**Please see Important Safety Information on page 11 and full Prescribing Information.**

# Takeda Oncology Here2Assist®

Takeda Oncology Here2Assist® is a **comprehensive support program** committed to helping patients navigate **coverage requirements**, identify available **financial assistance**, provide expert care and guidance with nurse-led **injection trainings**, and connect patients with helpful resources throughout their treatment.

Questions about enrolling in our support program?
**We have the answers.**

Models are used for illustrative purposes only.

**Let's Talk.** Call us at 1-844-817-6468, Option 2. We're available Monday-Friday, 8am-8pm ET

Enroll online at
**www.Here2Assist.com**

Takeda Oncology Here2Assist®

# INDICATION

MIMRYLO is indicated for the treatment of erythrocytosis in adults with polycythemia vera (PV).

# IMPORTANT SAFETY INFORMATION

## WARNINGS AND PRECAUTIONS

- **New or Worsening Thrombocytosis:** MIMRYLO may increase platelet counts in patients with PV. Platelet counts generally plateaued on treatment by Week 8. After initiating MIMRYLO and during dose modifications, monitor CBC every 2 to 4 weeks or as clinically indicated. Platelet elevations associated with MIMRYLO may require cytoreductive therapy initiation, modification, or MIMRYLO dose modifications or discontinuation.
- **Injection-Site Reactions:** Injection site reactions (including Grade 3 reactions) have been reported in patients treated with MIMRYLO. The most common injection site reactions reported were erythema, pruritus, pain, and swelling. Use ice, topical corticosteroid creams, antihistamines or analgesics, as needed, to treat injection site pain and swelling.
- **Embryo-Fetal Toxicity:** Based on findings from animal reproduction studies, MIMRYLO may cause fetal harm when administered to a pregnant woman. Advise patients to stop taking MIMRYLO if they become pregnant.

## ADVERSE REACTIONS

The most common (>15%) adverse reactions were injection site reactions (56%) and anemia (16%).

## USE IN SPECIFIC POPULATIONS

- **Lactation:** Because of the potential for serious adverse reactions in the breastfed child, including impaired iron absorption, advise patients not to breastfeed during treatment with MIMRYLO and for 30 days after the final treatment.
- **Females and Males of Reproductive Potential**
  - **Pregnancy Testing:** Prior to initiating MIMRYLO, pregnancy testing is recommended for females of reproductive potential.
  - **Contraception:** Advise female patients of reproductive potential to use effective contraception during treatment with MIMRYLO and for at least 30 days after the final dose of MIMRYLO.

To report SUSPECTED ADVERSE REACTIONS, contact Takeda Pharmaceuticals at 1-844-662-8532 or the FDA at 1-800-FDA-1088 or www.fda.gov/medwatch.

**Please see accompanying MIMRYLO (rusfertide) full Prescribing Information.**



**Reference:** Codify by AAPC. ICD-10-CM Code for Polycythemia vera D45. Accessed June 1, 2026. https://www.aapc.com/codes/icd-10-codes/D45?srsltid=AfmBOory0hLXiSrmP-layxfGo6iKzsAAqQzZoq8Si7JCm8sHIKsMF9Qd

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