SPECIALTY GUIDELINE MANAGEMENT

FERRIPROX (deferiprone)

POLICY

I. INDICATIONS

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

FDA-Approved Indication
Transfusional iron overload due to thalassemia syndromes when current chelation therapy is inadequate

All other indications are considered experimental/investigational and are not a covered benefit.

II. DOCUMENTATION

Submission of the following information is necessary to initiate the prior authorization review:
A. Initial requests: pretreatment serum ferritin level
B. Continuation requests: current serum ferritin level

III. CRITERIA FOR INITIAL APPROVAL

Transfusional Iron Overload
Authorization of 6 months may be granted for treatment of transfusional iron overload due to thalassemia syndromes when both of the following criteria are met:
A. Pretreatment serum ferritin level is consistently greater than 1000 mcg/L.
B. Dose of Ferriprox will not exceed 99 mg/kg per day.

IV. CONTINUATION OF THERAPY

Authorization of 6 months may be granted for continued treatment in members requesting reauthorization for an indication listed in Section III when both of the following criteria are met:
A. Member is experiencing benefit from therapy as evidenced by a decrease in serum ferritin levels as compared to pretreatment baseline.
B. Serum ferritin level is not consistently below 500 mcg/L.

V. REFERENCES