STANDARD COMMERCIAL DRUG FORMULARY
PRIOR AUTHORIZATION GUIDELINES

DEFERIPRONE

Generic	Brand	HICL	GCN	Medi-Span	Exception/Other
DEFERIPRONE	FERRIPROX, DEFERIPRONE	18544		GPI-10 (9310002800)	

GUIDELINES FOR USE

INITIAL CRITERIA (NOTE: FOR RENEWAL CRITERIA SEE BELOW)

1. Is the medication prescribed by or given in consultation with a hematologist or hematologist-oncologist?

   If yes, continue to #2.
   If no, do not approve.
   DENIAL TEXT: See the initial denial text at the end of the guideline.

2. Does the patient have a diagnosis of transfusional iron overload due to a thalassemia syndrome?

   If yes, continue to #3.
   If no, do not approve.
   DENIAL TEXT: See the initial denial text at the end of the guideline.

3. Has the patient had a trial of Exjade (deferasirox), Jadenu (deferasirox), or Desferal (deferoxamine)?

   If yes, continue to #4.
   If no, do not approve.
   DENIAL TEXT: See the initial denial text at the end of the guideline.

4. Is the request due to intolerable toxicities, clinically significant adverse effects, or contraindication to current chelation therapy with Exjade (deferasirox), Jadenu (deferasirox), or Desferal (deferoxamine)?

   If yes, **approve for 6 months by HICL or GPI-10.**
   APPROVAL TEXT: Renewal requires serum ferritin level consistently greater than 500mcg/L (at least 2 lab values in the previous 3 months).

   If no, continue to #5.

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DEFERIPRONE

INITIAL CRITERIA (CONTINUED)

5. Is the current chelation therapy (i.e., Exjade [deferasirox], Jadenu [deferasirox], or Desferal [deferoxamine]) inadequate as defined by one of the following criteria?
   - Serum ferritin levels consistently above 2500mcg/L (at least 2 lab values in the previous 3 months)
   - The patient has evidence of cardiac iron accumulation (i.e., cardiac T2* MRI <10 milliseconds, iron induced cardiomyopathy, fall in left ventricular ejection fraction [LVEF], arrhythmia indicating inadequate chelation)

   If yes, **approve for 6 months by HICL or GPI-10.**
   APPROVAL TEXT: Renewal requires serum ferritin level consistently greater than 500mcg/L (at least 2 lab values in the previous 3 months).

   If no, do not approve.
   INITIAL DENIAL TEXT: *Some terms are already pre-defined in parenthesis. Please use these definitions if the particular text you need to use does not already have definition(s) in it.

   Our guideline named **DEFERIPRONE (Ferriprox)** requires the following rule(s) be met for approval:
   A. You have transfusional iron overload due to a thalassemia syndrome (you have too much iron in your body due to a blood disorder)
   B. Therapy is prescribed by or given in consultation with a hematologist (blood specialty doctor) or hematologist-oncologist (tumor/cancer doctor)
   C. You have tried Exjade (deferasirox), Jadenu (deferasirox), or Desferal (deferoxamine)
   D. You meet ONE of the following:
      1. You are experiencing intolerable toxicities, clinically significant adverse effects, or have a contraindication to (medical reason why you cannot use) current chelation therapy (process of removing metals from the blood) with Exjade, Jadenu, or Desferal
      2. Chelation therapy (with Exjade [deferasirox], Jadenu [deferasirox], or Desferal [deferoxamine]) is not working well enough as shown by ONE of the following:
         a. Serum ferritin levels (amount of iron-containing blood cell proteins) stay above 2500mcg/L (at least 2 lab values in the previous 3 months)
         b. You have evidence of cardiac iron accumulation (iron build up in your heart) as defined by: cardiac T2* MRI less than 10 milliseconds, iron induced cardiomyopathy (heart disease), fall in left ventricular ejection fraction (LVEF: amount of blood your heart pumps out), arrhythmia indicating inadequate chelation (irregular heartbeat because iron was not lowered enough in body)

   Your doctor told us [INSERT PT SPECIFIC INFO PROVIDED]. We do not have information showing you [INSERT UNMET CRITERIA]. This is why your request is denied. Please work with your doctor to use a different medication or get us more information if it will allow us to approve this request.

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DEFERIPRONE

GUIDELINES FOR USE (CONTINUED)

RENEWAL CRITERIA

1. Does the patient have a diagnosis of transfusional iron overload due to a thalassemia syndrome **AND** meet the following criterion?
   - Serum ferritin levels consistently greater than 500mcg/L (at least 2 lab values in the previous 3 months)

   If yes, **approve for 12 months by HICL or GPI-10.**
   If no, do not approve.
   RENEWAL DENIAL TEXT: ***Some terms are already pre-defined in parenthesis. Please use these definitions if the particular text you need to use does not already have definition(s) in it.**

   Our guideline named **DEFERIPRONE (Ferriprox)** requires the following rule(s) be met for renewal:
   A. You have transfusional iron overload due to a thalassemia syndrome (you have too much iron in your body due to a blood disorder)
   B. Your serum ferritin levels (amount of iron-containing blood cell proteins) stay greater than 500mcg/L (at least 2 lab values in the previous 3 months)

   Your doctor told us [INSERT PT SPECIFIC INFO PROVIDED]. We do not have information showing you [INSERT UNMET CRITERIA]. This is why your request is denied. Please work with your doctor to use a different medication or get us more information if it will allow us to approve this request.

RATIONALE

For further information, please refer to the Prescribing Information and/or Drug Monograph for Ferriprox.

REFERENCES

- Ferriprox [Prescribing Information]. Weston, FL: ApoPharma USA, Inc.; February 2020.

Library	Commercial	NSA
Yes	Yes	No

Part D Effective: N/A
Commercial Effective: 10/12/20
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