



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. Does the patient have **ONE** of the following diagnoses?

- Transfusional iron overload due to thalassemia syndrome
- Transfusional iron overload due to sickle cell disease or other anemias

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 meet **ALL** of the following criteria?

- Therapy is prescribed by or given in consultation with a hematologist or hematologist/oncologist
- The patient had a trial of or contraindication to at least **ONE** of the following: Exjade (deferasirox), Jadenu (deferasirox), or Desferal (deferoxamine)

If yes, continue to #3.

If no, do not approve.

DENIAL TEXT: See the initial denial text at the end of the guideline.

3. Is the patient experiencing intolerable toxicities, clinically significant adverse effects, has a contraindication to current chelators: Exjade (deferasirox), Jadenu (deferasirox), or Desferal (deferoxamine), **OR** current chelation therapy is inadequate?

If yes, continue to #4.

If no, do not approve.

DENIAL TEXT: See the initial denial text at the end of the guideline.

4. Does the patient meet **ONE** of the following criteria?

- The request is for Ferriprox (deferiprone) tablets **AND** the patient is 8 years of age or older
- The request is for Ferriprox oral solution **AND** the patient is 3 years of age or older

If yes, **approve for 6 months for all strengths of the requested formulation by GPID or GPI-14.**

If no, do not approve.

DENIAL TEXT: See the initial denial text at the end of the guideline.

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INITIAL CRITERIA (CONTINUED)

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 ONE of the following diagnoses:
 - 1. Transfusional iron overload due to a thalassemia syndrome (you have too much iron in your body due to a type of blood disorder)
 - 2. Transfusional iron overload due to a sickle cell disease or other anemias (you have too much iron in your body due to a type of blood disorder)
- B. Therapy is prescribed by or given in consultation with a hematologist (a type of blood doctor) or hematologist/oncologist (a type of cancer doctor)
- C. You have tried or have a contraindication (harmful for) to at least ONE of the following: Exjade (deferasirox), Jadenu (deferasirox), or Desferal (deferoxamine)
- D. You meet ONE of the following:
 - 1. You are experiencing intolerable toxicities or clinically significant adverse effects or have a contraindication (harmful for) to current chelators (drugs that bind to iron): Exjade (deferasirox), Jadenu (deferasirox), or Desferal (deferoxamine)
 - 2. Current chelation therapy (therapy that lowers iron levels) with Exjade [deferasirox], Jadenu [deferasirox], or Desferal [deferoxamine] is not working well enough
- E. **If the request is for Ferriprox (deferiprone) tablets, approval also requires:**
 - 1. You are 8 years of age or older
- F. **If the request is for Ferriprox oral solution, approval also requires:**
 - 1. You are 3 years of age or older

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.

RENEWAL CRITERIA

- 1. Does the patient have **ONE** of the following diagnoses?
 - Transfusional iron overload due to thalassemia syndrome
 - Transfusional iron overload due to a sickle cell disease or other anemias

If yes, continue to #2.

If no, do not approve.

DENIAL TEXT: See the renewal denial text at the end of the guideline.

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RENEWAL CRITERIA (CONTINUED)

2. Does the patient meet the following criterion?

- The patient has serum ferritin levels consistently greater than 500mcg/L (at least 2 lab values in the previous 3 months)

If yes, continue to #3.

If no, do not approve.

DENIAL TEXT: See the renewal denial text at the end of the guideline.

3. Does the patient meet **ONE** of the following criteria?

- The request is for Ferriprox (deferiprone) tablets **AND** the patient is 8 years of age or older
- The request is for Ferriprox oral solution **AND** the patient is 3 years of age or older

If yes, **approve for 12 months for all strengths of the requested formulation by GPID or GPI-14.**

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 **ONE** of the following diagnoses:

1. Transfusional iron overload due to thalassemia syndrome (you have too much iron in your body due to a type of blood disorder)
2. Transfusional iron overload due to a sickle cell disease or other anemias (you have too much iron in your body due to a type of blood disorder)

B. Your serum ferritin levels (amount of iron-containing blood cell proteins) stay above 500mcg/L (at least 2 lab values in the previous 3 months)

C. **If the request is for Ferriprox (deferiprone) tablets, approval also requires:**

1. You are 8 years of age or older

D. **If the request is for Ferriprox oral solution, approval also requires:**

1. You are 3 years of age or older

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

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.; April 2021.

Library	Commercial	NSA
Yes	Yes	No

Part D Effective: N/A

Commercial Effective: 04/01/22

Created: 08/17

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P&T Approval: 01/22