Pharmacy Drug Policy Checklist

POLICY NAME	Ferriprox (deferiprone)	POLICY #	1946P

Criteria

Criteria for Coverage in the Treatment of Transfusional Iron Overload

- ☐ **1.1** Documentation which shows the iron overload is due to thalassemia syndromes (oral tablets), or sickle cell disease/other anemias (oral solution)
- ☐ **1.2** Age 3 years or older for oral solution; Age 8 years or older for oral tablets
- ☐ **1.3** Documentation of failure/intolerance/contraindication of other agent for the treatment of transfusional iron overload (e.g. deferasirox),
- ☐ **1.4** Serum ferritin (blood iron) level greater than 1000 ng/dL
- ☐ **1.5** Submission of baseline absolute neutrophil count greater than or equal to 1.5 x 109/L

Approval Time

- ☐ **2.1** Initial: 12 months
- ☐ **2.2** Reauthorization: 12 months only if ongoing need for therapy has been established CPT Codes HCPCS Codes