

POLICY NAME	Ferriprox (deferiprone)	POLICY #	1946P
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Criteria

Criteria for Coverage in the Treatment of Transfusional Iron Overload

- ☐ Documentation which shows the iron overload is due to thalassemia syndromes (oral tablets), or sickle cell disease/other anemias (oral solution)
- ☐ Age 3 years or older for oral solution; Age 8 years or older for oral tablets
- ☐ Documentation of failure/intolerance/contraindication of other agent for the treatment of transfusional iron overload (e.g. deferasirox),
- ☐ Serum ferritin (blood iron) level greater than 1000 ng/dL
- ☐ Submission of baseline absolute neutrophil count greater than or equal to $1.5 \times 10^9/L$