Ferriprox (deferiprone)

Coverage Criteria:

Reserved for patients:

1. With transfusion induced iron overload due to thalassemia syndromes, sickle cell disease, or other anemias; and,
2. Iron levels uncontrolled on prior iron chelation therapy or have a contraindication to; and,
    a. Jadenu (deferasirox), dosing up to 28mg/kg

    Or

    b. Exjade (defersirox), dosing up to 40 mg/kg

    AND

    c. Desferal (deferoxamine), dosing up to:
        i. IM up to 1000 mg/day
        ii. IV up to 60 mg/kg/day
        iii. Subcutaneous 2,000 mg/day

3. When prescribed by a hematology-oncology specialist; and,

4. The patient and/or guardian has attested that they will adhere to the treatment plan; and

5. Requests for brand Ferriprox require a documented allergic reaction to generic deferiprone.

6. When prescribed according to the FDA approved regimen of 25 mg/kg to 33 mg/kg given three times daily.

Required Medical Information:

Current body weight is required.

Coverage Duration:

Initial authorizations will be for 12 months.

Renewal Criteria:

Annual reauthorizations will require medical chart documentation that the patient has been seen within the past 12 months and that markers of disease are improved by therapy.

These include but may not be limited to:

1. Reduction in serum ferritin levels, and;
2. A statement of progress against therapy goals.

P&T Date: August 2016
Effective Date: 6/1/2021, Updated 6/8/2023