

Clinical Policy: Deferiprone (Ferriprox)

Reference Number: CP.PHAR.147

Effective Date: 11.01.15

Last Review Date: 08.18

Line of Business: Commercial, HIM, Medicaid

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

Description

Deferiprone (Ferriprox[®]) is an iron chelator.

FDA Approved Indication(s)

Ferriprox is indicated for the treatment of patients with transfusional iron overload due to thalassemia syndromes when current chelation therapy is inadequate.

Limitation(s) of use: Safety and effectiveness have not been established for the treatment of transfusional iron overload in patients with other chronic anemias.

Policy/Criteria

Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation[®] that Ferriprox is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Transfusional Iron Overload due to Thalassemia Syndromes (must meet all):

1. Diagnosis of transfusional iron overload due to thalassemia syndromes;
2. Age \geq 18 years;
3. Transfusion history of \geq 100 mL/kg of packed red blood cells (e.g., \geq 20 units of packed red blood cells for a 40 kg person) and a serum ferritin level $>$ 1,000 mcg/L;
4. Failure of deferoxamine and either Exjade[®] or Jadenu[®] unless contraindicated or clinically significant adverse effects are experienced;
5. Dose does not exceed 99 mg/kg/day.

Approval duration: 6 months

B. Other diagnoses/indications

1. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.CPA.09 for commercial, HIM.PHAR.21 for health insurance marketplace, and CP.PMN.53 for Medicaid.

II. Continued Therapy

A. Transfusional Iron Overload due to Thalassemia Syndromes (must meet all):

1. Currently receiving medication via Centene benefit or member has previously met all initial approval criteria;
2. Current documentation (within the past 30 days) shows a serum ferritin level ≥ 500 mcg/L.
3. If request is for a dose increase, new dose does not exceed 99 mg/kg/day.

Approval duration: 12 months

B. Other diagnoses/indications (must meet 1 or 2):

1. Currently receiving medication via Centene benefit and documentation supports positive response to therapy.
Approval duration: Duration of request or 6 months (whichever is less); or
2. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.CPA.09 for commercial, HIM.PHAR.21 for health insurance marketplace, and CP.PMN.53 for Medicaid.

III. Diagnoses/Indications for which coverage is NOT authorized:

- A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies – CP.CPA.09 for commercial, HIM.PHAR.21 for health insurance marketplace, and CP.PMN.53 for Medicaid or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

DFO-DFP: deferiprone-deferoxamine

FDA: Food and Drug Administration

Appendix B: Therapeutic Alternatives

This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent for all relevant lines of business and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Deferoxamine (Desferal [®])	1000 mg x 1 dose, then 500 mg Q4 hr x 2 doses PRN, then 500 mg Q4-12 hr PRN.*	6000 mg/24 hr

	*IM route if patient not in shock; IV infusion limited to patients in cardiovascular collapse.	
	1000-2000 mg SC QD (20-40 mg/kg/day) over 8-24 hours.	See dosing regimen
	20-40 mg/kg IV daily (children*) and 40-50 mg/kg IV daily (adults) for 5-7 days per week.	40 mg/kg/day (children) 60 mg/kg/day (adults)

*Average dose should not exceed 40 mg/kg/day until growth has ceased.		
500-1000 mg IM/day.		1000 mg/day

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Exjade [®] (deferasirox)	20 to 40 mg/kg (calculated to the nearest whole tablet) PO QD	40 mg/kg/day
Jadenu [®] (deferasirox)	14 mg/kg (calculated to the nearest whole tablet) PO QD	14 mg/kg (calculated to the nearest whole tablet)

Therapeutic alternatives are listed as Brand name[®] (generic) when the drug is available by brand name only and generic (Brand name[®]) when the drug is available by both brand and generic.

Appendix C: Contraindications

Not applicable

Appendix D: Boxed Warning

Agranulocytosis/Neutropenia

- Ferriprox can cause agranulocytosis that can lead to serious infections and death. Neutropenia may precede the development of agranulocytosis.
- Measure the absolute neutrophil count before starting Ferriprox therapy and monitor the ANC weekly on therapy. Interrupt Ferriprox therapy if neutropenia develops.
- Interrupt Ferriprox if infection develops, and monitor the ANC more frequently.
- Advise patients taking Ferriprox to report immediately any symptoms indicative of infection.

Appendix E: General Information

- A multicentre randomized open-label trial was designed to assess the effectiveness of long-term sequential deferiprone-deferoxamine (DFO-DFP) versus DFP alone to treat thalassaemia major. The decrease of serum ferritin levels during the treatment period was statistically significantly higher in sequential DFP-DFO patients compared with DFP-alone patients (P = 0.005). Kaplan-Meier survival analysis for the two chelation treatments did not show any statistically significant differences (long-rank test, P = 0.3145).
- Evidence exists to support the use of combination therapy with Ferriprox (deferiprone) and Desferal (deferoxamine) in patients with severe iron overload or overt iron-related morbidity.

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Transfusional iron overload	25 to 33 mg/kg PO TID for a total daily dose of 75 to 99 mg/kg/day	99 mg/kg/day

VI. Product Availability

Oral solution: 100 mg/mL

Tablet: 500 mg

VII. References

1. Ferriprox Prescribing Information. Rockville, MD: ApoPharma USA, Inc.; May 2017. Available at http://www.ferriprox.com/us/pdf/ferriprox_full_pi.pdf. Accessed April 2018.
2. Ferriprox Oral Solution Prescribing Information. Rockville, MD: ApoPharma USA, Inc.; May 2017. Available at http://www.ferriprox.com/us/pdf/ferriprox_full_pi.pdf. Accessed April 2018.
3. Desferal Prescribing Information. East Hanover, NJ: Novartis Pharmaceuticals Corporation; December 2011. Available at <https://dailymed.nlm.nih.gov/dailymed/>. Accessed April 2018.
4. Exjade Prescribing Information. East Hanover, NJ: Novartis Pharmaceuticals Corporation; August 2016. Available at <http://www.us.exjade.com/>. Accessed April 2018.
5. Jadenu Prescribing Information. East Hanover, NJ: Novartis Pharmaceuticals Corporation; August 2016. Available at <https://www.jadenu.com/>. Accessed April 2018.
6. Musallam KM, Angastiniotis M, Eleftheriou A, Porter JB. Cross-talk between available guidelines for the management of patients with beta-thalassemia major. *Acta Haematol.* 2013; 130: 64-73. DOI: 10.1159/000345734.
7. Hoffbrand AV, Taher A, Cappellini MD. How I treat transfusional iron overload. *Blood.* November 1, 2012; 120(18): 3657-3669.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Moved Ferriprox to independent policy Ferriprox criteria - added age criteria (adults); removed requests for documentation; reformatted using appendices and added question about ferritin levels in the continuation of therapy section.	11.15	11.15
Converted policy to new template. Age removed and documentation requests added; “current documentation” is defined as “within the last 30 days” for follow-up serum ferritin levels and recommended monthly ferritin tests. Initiation of therapy: transfusion history and serum ferritin level per the PI dosing information; the wording “and consistent ferritin levels >1,000” is changed to “or a serum ferritin level >1,000.”	10.16	11.16
Converted to new template. Approval duration extended to 6 and 12 months, from 3 and 6 months initial and re-auth respectively. Added weight-based max dose per PI; safety criteria was applied according to the safety guidance discussed at CPAC and endorsed by Centene Medical Affairs.	05.17	P&T: 08.17 CPC: 11.17
3Q 2018 annual review: policies combined for Centene Medicaid, HIM (new) and Commercial (new) lines of business; no significant changes; references reviewed and updated.	04.27.18	08.18

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program

approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

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Note:

For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

For Health Insurance Marketplace members, when applicable, this policy applies only when the prescribed agent is on your health plan approved formulary. Request for non-formulary drugs must be reviewed using the formulary exception policy.

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