



Original Effective Date: 10/01/2018
Current Effective Date: 09/06/2023
Last P&T Approval/Version: 07/26/2023
Next Review Due By: 07/2024
Policy Number: C15214-A

Iron Chelating Agents (Desferal, Exjade, Ferriprox, Jadenu)

PRODUCTS AFFECTED

Desferal (deferoxamine), Exjade (deferasirox), Jadenu (deferasirox), Ferriprox (deferiprone)

COVERAGE POLICY

Coverage for services, procedures, medical devices, and drugs are dependent upon benefit eligibility as outlined in the member's specific benefit plan. This Coverage Guideline must be read in its entirety to determine coverage eligibility, if any.

This Coverage Guideline provides information related to coverage determinations only and does not imply that a service or treatment is clinically appropriate or inappropriate. The provider and the member are responsible for all decisions regarding the appropriateness of care. Providers should provide Molina Healthcare complete medical rationale when requesting any exceptions to these guidelines.

Documentation Requirements:

Molina Healthcare reserves the right to require that additional documentation be made available as part of its coverage determination; quality improvement; and fraud; waste and abuse prevention processes. Documentation required may include, but is not limited to, patient records, test results and credentials of the provider ordering or performing a drug or service. Molina Healthcare may deny reimbursement or take additional appropriate action if the documentation provided does not support the initial determination that the drugs or services were medically necessary, not investigational or experimental, and otherwise within the scope of benefits afforded to the member, and/or the documentation demonstrates a pattern of billing or other practice that is inappropriate or excessive.

DIAGNOSIS:

Acute iron intoxication, Chronic iron overload due to blood transfusions (transfusional iron overload), Chronic iron overload in non-transfusion dependent thalassemia syndromes, Transfusional iron overload due to thalassemia syndromes

REQUIRED MEDICAL INFORMATION:

This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. If a drug within this policy receives an updated FDA label within the last 180 days, medical necessity for the member will be reviewed using the updated FDA label information along with state and federal requirements, benefit being administered and formulary preferencing. Coverage will be determined on a case-by case basis until the criteria can be updated through Molina Healthcare, Inc. clinical governance. Additional information may be required on a case-by-case basis to allow for adequate review. When the requested drug product for coverage is dosed by weight, body surface area or other member specific measurement, this data element is required as part of the medical necessity review.

A. FOR EXJADE/JADENU (DEFERASIROX):

1. Documentation of either of the following diagnosis:
 - (a) i. Chronic transfusional iron overload due to blood transfusions

Molina Healthcare, Inc. confidential and proprietary © 2023

This document contains confidential and proprietary information of Molina Healthcare and cannot be reproduced, distributed, or printed without written permission from Molina Healthcare. This page contains prescription brand name drugs that are trademarks or registered trademarks of pharmaceutical manufacturers that are not affiliated with Molina Healthcare.

Drug and Biologic Coverage Criteria

- AND
- ii. Transfusion history of ≥ 100 mL/kg of packed red blood cells (e.g., ≥ 20 units of packed red blood cells for a 40 kg person) AND a serum ferritin level $> 1,000$ mcg/L [DOCUMENTATION REQUIRED]
- OR
- (b) i. Chronic iron overload resulting from non-transfusion dependent thalassemia (NTDT)
AND
 - ii. Documentation of a liver iron concentration (LIC) greater than or equal to 5 milligrams of iron per gram of liver dry weight (mg Fe/g dw) and a serum ferritin greater than 300 mcg/L. [DOCUMENTATION REQUIRED]
- AND
- 2. Prescriber attests to (or the clinical reviewer has found that) the member not having any FDA labeled contraindications that haven't been addressed by the prescriber within the documentation submitted for review [Contraindications to deferasirox include: estimated GFR less than 40 mL/min/1.73 m², poor performance status, high-risk myelodysplastic syndrome (MDS), advanced malignancies, platelet count less than $50 \times 10^9/L$, known hypersensitivity to deferasirox or any component of the requested product, severe (Child-Pugh C) hepatic impairment, use with nephrotoxic drugs]
AND
 - 3. Prescriber attests to member appropriate monitoring as recommended within drug label including, but not limited to ophthalmologic exams, kidney function testing, liver transaminases and bilirubin, and auditory testing
AND
 - 4. IF THE REQUEST NON-FORMULARY/ NON-PREFERRED PRODUCT: Documentation of trial/failure of or intolerance to a majority (not more than 3) of the preferred formulary/PDL alternatives for the given diagnosis. Submit documentation including medication(s) tried, dates of trial(s) and reason for treatment failure(s).

B. FOR FERRIPROX (DEFERIPRONE):

- 1. Documented diagnosis of transfusional iron overload due to thalassemia syndrome, sickle cell disease or other anemias
AND
- 2. Documentation of an inadequate response (as defined by serum ferritin $>2,500$ mcg/L), serious side effects, or a labeled contraindication to Desferal (deferroxamine) AND Exjade (deferasirox) or Jadenu (deferasirox)
AND
- 3. Documentation serum ferritin levels are consistently > 2500 mcg/L demonstrated by at least 2 lab values in the previous 3 months [DOCUMENTATION REQUIRED]
AND
- 4. Documentation of member's absolute neutrophil count (ANC) $>1.5 \times 10^9/L$ [DOCUMENTATION REQUIRED]
AND
- 5. Prescriber attests to appropriate monitoring as recommended within drug label including, but not limited to, ANC (weekly for the first 6 months of therapy, then once every two week for the next 6 months of therapy, then every two to four weeks after one year of therapy), ALT (before and monthly during therapy), Zinc levels (before and regularly during therapy)
AND
- 6. For women of child-bearing potential: Provider attests that member is NOT pregnant or planning on becoming pregnant
AND
- 7. For women of child-bearing potential or males with female partners of child-bearing potential: Prescriber attests that member has been counseled to use an effective method of contraception during treatment and for at least six months (females) or 3 months (males) after the last dose

Drug and Biologic Coverage Criteria

C. FOR DESFERAL (DEFEROXAMINE):

1. Documentation of either of the following diagnosis:
 - (a) Acute iron intoxication
 - OR
 - (b) i. Chronic iron overload due to transfusion-dependent anemia (e.g., congenital/acquired anemias including thalassemia, sickle cell anemia, aplastic anemia, myelodysplasia)
AND
ii. Member has a Transfusion history of ≥ 100 mL/kg of packed red blood cells (e.g., ≥ 20 units of packed red blood cells for a 40 kg person) AND a serum ferritin level $>1,000$ mcg/L [DOCUMENTATION REQUIRED]
- AND
2. Prescriber attests to member appropriate monitoring as recommended within drug label (visual acuity tests, slit-lamp examinations, funduscopy and audiometry are recommended periodically in patients treated for prolonged periods of time; monitor renal function).
AND
3. Prescriber attests to (or the clinical reviewer has found that) the member not having any FDA labeled contraindications that haven't been addressed by the prescriber within the documentation submitted for review [Contraindications to deferoxamine include: known hypersensitivity to the active substance, patients with severe renal disease or anuria.]

CONTINUATION OF THERAPY:

A. FOR EXJADE/JADENU (DEFERASIROX): CHRONIC IRON OVERLOAD DUE TO BLOOD TRANSFUSIONS:

1. Documentation showing member's current (within last 30 days) serum ferritin level ≥ 500 mcg/L [DOCUMENTATION REQUIRED]
AND
2. Prescriber attests to continued serum ferritin level monitoring and adjusting member's dose, if necessary, every 3 to 6 months based on serum ferritin levels
AND
3. Prescriber attests (or the clinical reviewer has found) that at time of request, member's estimated glomerular filtration rate is NOT less than 40mL/min/1.73m² or platelet count less than 50 x 10⁹/L
AND
4. Prescriber attests to continued appropriate monitoring as recommended within drug label including, but not limited to visual acuity tests, kidney function, liver transaminases and bilirubin and auditory testing
AND
5. Prescriber attests to or clinical reviewer has found no evidence of intolerable adverse effects or drug toxicity

B. FOR EXJADE/JADENU (DEFERASIROX): CHRONIC IRON OVERLOAD DUE TO NON-TRANSFUSION DEPENDENT THALASSEMIA SYNDROME:

1. (a) If member has received < 6 months of Exjade/Jadenu, a serum ferritin level ≥ 300 mcg/L or an LIC ≥ 3 mg Fe/g dw [DOCUMENTATION REQUIRED]
OR
(b) If member has received ≥ 6 months of Exjade/Jadenu, an LIC is ≥ 3 mg Fe/g dw [DOCUMENTATION REQUIRED]
AND
2. Prescriber attests (or the clinical reviewer has found) that at time of request, member's estimated glomerular filtration rate is NOT less than 40 mL/min/1.73m² or platelet count less than 50 x 10⁹/L
AND
3. Prescriber attests to continued appropriate monitoring as recommended within drug label including, but not limited to visual acuity tests, kidney function, and auditory testing

Drug and Biologic Coverage Criteria

AND

4. Prescriber attests to or clinical reviewer has found no evidence of intolerable adverse effects or drug toxicity

C. FOR FERRIPROX (DEFERIPRONE): TRANSFUSIONAL IRON OVERLOAD DUE TO THALASSEMIA SYNDROME, SICKLE CELL DISEASE OR OTHER ANEMIAS:

1. Documentation of current (within the past 30 days) member's serum ferritin level ≥ 500 mcg/L
[DOCUMENTATION REQUIRED]
AND
2. Prescriber attests to continued appropriate monitoring as recommended within drug label including but not limited to ANC (weekly for the first 6 months of therapy, then once every two weeks for the next 6 months of therapy, then every two to four weeks after one year of therapy), ALT (before and monthly during therapy), Zinc levels (before and regularly during therapy)
AND
3. For women of child-bearing potential or males with female partners of child-bearing potential: Prescriber attests member or their partner is not pregnant, and member has been counseled to use an effective method of contraception during treatment and for at least six months (females) or 3 months (males) after the last dose
AND
4. Prescriber attests to or clinical reviewer has found no evidence of intolerable adverse effects or drug toxicity

D. FOR DESFERAL (DEFEROXAMINE): CHRONIC IRON OVERLOAD DUE TO BLOOD TRANSFUSIONS:

1. Documentation showing member's current (within last 30 days) serum ferritin level ≥ 500 mcg/L
[DOCUMENTATION REQUIRED]
AND
2. Prescriber attests to continued serum ferritin level monitoring and adjusting member's dose if necessary, every 3 to 6 months based on serum ferritin levels
AND
3. Prescriber attests to member appropriate monitoring as recommended within drug label (visual acuity tests, slit-lamp examinations, funduscopy and audiometry are recommended periodically in patients treated for prolonged periods of time; monitor renal function).
AND
4. Prescriber attests to or clinical reviewer has found no evidence of intolerable adverse effects or drug toxicity

DURATION OF APPROVAL:

ACUTE IRON TOXICITY: Initial authorization: 3 months, Continuation of therapy: NA

ALL OTHER INDICATIONS: Initial authorization: 3 months, Continuation of Therapy: 6 months

PRESCRIBER REQUIREMENTS:

Prescribed by or in consultation with a board-certified hematologist or oncologist. [If prescribed in consultation, consultation notes must be submitted with initial request and reauthorization requests]

AGE RESTRICTIONS:

Exjade/Jadenu:

Transfusional iron overload: 2 years of age and older

Chronic iron overload in non-transfusion dependent thalassemia (NTDT): 10 years of age and older

Ferriprox: Tablets: 8 years of age and older; Oral Solution: 3 years of age and older

Desferal: 3 years of age and older

QUANTITY:

Desferal (deferoxamine):

Drug and Biologic Coverage Criteria

Acute Iron Toxicity:

IM: 1000 mg initially. This may be followed by 500 mg every 4 hours for two doses. Depending upon the clinical response, subsequent doses of 500 mg may be administered every 4-12 hours. The total amount administered should not exceed 6000 mg in 24 hours.

IV: An initial dose of 1000 mg should be administered at a rate NOT TO EXCEED 15 mg/kg/hr. This may be followed by 500 mg over 4 hours for two doses. Depending upon the clinical response, subsequent doses of 500 mg may be administered over 4-12 hours. The total amount administered should not exceed 6000 mg in 24 hours.

Chronic Iron Overload:

SC: 1000-2000 mg/day (20-40 mg/kg/day)

IV: Maximum 40 mg/kg/day for children and maximum 60 mg/kg/day in adults

IM: 1000 mg/day

Exjade (deferasirox):

Transfusional Iron Overload: Initial: 20 mg/kg/day. Maximum: 40 mg/kg/day

NTDT Syndromes: Initial: 10 mg/kg/day. Maximum: 20 mg/kg/day

Jadenu (deferasirox):

Transfusional Iron Overload: Initial: 14 mg/kg/day. Maximum: 28mg/kg/day

NTDT Syndromes: Initial: 7 mg/kg/day. Maximum: 14 mg/kg/day

Ferriprox (deferiprone) [tablets and oral solution]:

Initial: 75mg/kg/day. Individualize dose based on response and therapeutic goal. Maximum dose: 99 mg/kg/day.

Maximum Quantity Limits – << based on FDA label>>

PLACE OF ADMINISTRATION:

Desferal (deferoxamine): The recommendation is that infused and injectable medications in this policy will be for pharmacy or medical benefit coverage and the intramuscular or subcutaneous injectable products be administered in a place of service that is a non-inpatient hospital facility-based location.

Exjade (deferasirox), Jadenu (deferasirox) and Ferriprox (deferiprone):

The recommendation is that oral medications in this policy will be for pharmacy benefit coverage and patient self-administered.

DRUG INFORMATION

ROUTE OF ADMINISTRATION:

Oral, Intramuscular, Intravenous, Subcutaneous

DRUG CLASS:

Antidotes - Chelating Agents

FDA-APPROVED USES:

Desferal (deferoxamine):

Indicated as an adjunct to standard measures for the treatment of acute iron intoxication and for the treatment of transfusional iron overload in patients with chronic anemia.

Limitations of Use: Desferal is not indicated for the treatment of primary hemochromatosis (since phlebotomy is the method of choice for removing excess iron in this disorder).

Exjade/Jadenu (deferasirox):

Indicated for the treatment of chronic iron overload due to blood transfusions in patients 2 years of age and older; for the treatment of chronic iron overload in patients 10 years of age and older with non-

Molina Healthcare, Inc. confidential and proprietary © 2023

This document contains confidential and proprietary information of Molina Healthcare and cannot be reproduced, distributed, or printed without written permission from Molina Healthcare. This page contains prescription brand name drugs that are trademarks or registered trademarks of pharmaceutical manufacturers that are not affiliated with Molina Healthcare.

Drug and Biologic Coverage Criteria

transfusion dependent thalassemia (NTDT) syndromes, and with a liver iron (Fe) concentration (LIC) of at least 5 mg Fe per gram of dry weight and a serum ferritin greater than 300 mcg/L.

Limitations of Use: The safety and efficacy of Exjade and Jadenu when administered with other iron chelation therapy have not been established.

Ferriprox (deferiprone) tablets:

Indicated for the treatment of transfusional iron overload in adult and pediatric patients 8 years of age and older with sickle cell disease or other anemias.

Ferriprox (deferiprone) oral solution:

Indicated for the treatment of transfusional iron overload in adult and pediatric patients 3 years of age and older with thalassemia syndromes, sickle cell disease or other anemias.

Limitations of use: Safety and effectiveness have not been established for the treatment of transfusional iron overload in patients with myelodysplastic syndrome or in patients with Diamond Blackfan anemia.

COMPENDIAL APPROVED OFF-LABELED USES:

None

APPENDIX

APPENDIX:

Reserved for State specific information. Information includes, but is not limited to, State contract language, Medicaid criteria and other mandated criteria.

State Specific Information

State Marketplace

Illinois (Source: [Illinois General Assembly](#))

“(215 ILCS 200/60) Sec. 60. Length of prior authorization approval. *A prior authorization approval shall be valid for the lesser of 6 months after the date the health care professional or health care provider receives the prior authorization approval or the length of treatment as determined by the patient's health care professional or the renewal of the plan, and the approval period shall be effective regardless of any changes, including any changes in dosage for a prescription drug prescribed by the health care professional. All dosage increases must be based on established evidentiary standards and nothing in this Section shall prohibit a health insurance issuer from having safety edits in place. This Section shall not apply to the prescription of benzodiazepines or Schedule II narcotic drugs, such as opioids. Except to the extent required by medical exceptions processes for prescription drugs set forth in Section 45.1 of the Managed Care Reform and Patient Rights Act, nothing in this Section shall require a policy to cover any care, treatment, or services for any health condition that the terms of coverage otherwise completely exclude from the policy's covered benefits without regard for whether the care, treatment, or services are medically necessary. (Source: P.A. 102-409, eff. 1-1-22.)*”

“(215 ILCS 200/65) Sec. 65. Length of prior authorization approval for *treatment for chronic or long-term conditions*. If a health insurance issuer requires a prior authorization for a recurring health care service or maintenance medication for the treatment of a chronic or long-term condition, *the approval shall remain valid for the lesser of 12 months from the date the health care professional or health care provider receives the prior authorization approval or the length of the treatment as determined by the patient's health care professional*. This Section shall not apply to the prescription of benzodiazepines or Schedule II narcotic drugs, such as opioids. Except to the extent required by medical exceptions processes for prescription drugs set forth in Section 45.1 of the Managed Care Reform and Patient Rights Act, nothing in this Section shall require a policy to cover any care, treatment, or services for any health condition that the terms of coverage otherwise completely exclude from the policy's covered benefits without regard for whether the care, treatment, or services are medically necessary. (Source: P.A. 102-409, eff. 1-1-22.)”

Kentucky (Source: [Kentucky Revised Statutes](#))

KY304.17A-167 Time span of authorizations

(Subsection 2) “Unless otherwise provided in subsection (3) of this section or prohibited by state or federal

Molina Healthcare, Inc. confidential and proprietary © 2023

This document contains confidential and proprietary information of Molina Healthcare and cannot be reproduced, distributed, or printed without written permission from Molina Healthcare. This page contains prescription brand name drugs that are trademarks or registered trademarks of pharmaceutical manufacturers that are not affiliated with Molina Healthcare.

Drug and Biologic Coverage Criteria

law, if a provider receives a prior authorization for a drug prescribed to a covered person with a condition that requires ongoing medication therapy, and the provider continues to prescribe the drug, and the drug is used for a condition that is within the scope of use approved by the United States Food and Drug Administration or has been proven to be a safe and effective form of treatment for the patient's specific underlying condition based on clinical practice guidelines that are developed from peer-reviewed publications, the prior authorization received shall: (a) Be valid for the lesser of: 1. One (1) year from the date the provider receives the prior authorization; or 2. Until the last day of coverage under the covered person's health benefit plan during a single plan year; and (b) Cover any change in dosage prescribed by the provider during the period of authorization." (Subsection 3) "Except as provided in paragraph (b) of this subsection, the provisions of subsection (2) of this section shall not apply to: 1. Medications that are prescribed for a non-maintenance condition; 2. Medications that have a typical treatment period of less than twelve (12) months; 3. Medications where there is medical or scientific evidence that does not support a twelve (12) month approval; or 4. Medications that are opioid analgesics or benzodiazepines. (b) Paragraph (a) of this subsection shall not apply to any medication that is prescribed to a patient in a community-based palliative care program."

Re-authorization (approved authorization previously issued by Molina Healthcare) for maintenance medications within this policy shall be approved for a 12 month duration when request meets policy requirements, unless exceptions noted above have been met.

Mississippi (Source: [Mississippi Legislature](#))

"SECTION 13. Length of approvals. (1) A prior authorization approval shall be valid for the lesser of six (6) months after the date the health care professional or health care provider receives the prior authorization approval or the length of treatment as determined by the patient's health care professional or the renewal of the policy or plan, and the approval period shall be effective regardless of any changes, including any changes in dosage for a prescription drug prescribed by the health care professional. Notwithstanding the foregoing, a health insurer and an enrollee or his/her health care professional may extend a prior authorization approval for a longer period, by agreement. All dosage increases must be based on established evidentiary standards, and nothing in this section shall prohibit a health insurance issuer from having safety edits in place. This section shall not apply to the prescription of benzodiazepines or Schedule II narcotic drugs, such as opioids.

(2) Nothing in this section shall require a policy or plan to cover any care, treatment, or services for any health condition that the terms of coverage otherwise completely exclude from the policy's or plan's covered benefits without regard for whether the care, treatment or services are medically necessary.

SECTION 14. Approvals for chronic conditions. (1) If a health insurance issuer requires a prior authorization for a recurring health care service or maintenance medication for the treatment of a chronic or long-term condition, including, but not limited to, chemotherapy for the treatment of cancer, the approval shall remain valid for the lesser of twelve (12) months from the date the health care professional or health care provider receives the prior authorization approval or the length of the treatment as determined by the patient's health care professional. Notwithstanding the foregoing, a health insurer and an enrollee or his or her health care professional may extend a prior authorization approval for a longer period, by agreement. This section shall not apply to the prescription of benzodiazepines or Schedule II narcotic drugs, such as opioids.

(2) Nothing in this section shall require a policy or plan to cover any care, treatment or services for any health condition that the terms of coverage otherwise completely exclude from the policy's or plan's covered benefits without regard for whether the care, treatment, or services are medically necessary."

Ohio (Source: [Ohio Revised Code](#))

Chapter 3923 Sickness And Accident Insurance Section 3923.041 Policies with prior authorization requirement provisions "(B)(6)(a) For policies issued on or after January 1, 2017, *for a prior approval related to a chronic condition*, the insurer or plan shall honor a prior authorization *approval for an approved drug for the lesser of the following from the date of the approval: (i) Twelve months; (ii) The last day of the covered person's eligibility under the policy or plan.* (b) The duration of all other prior authorization approvals shall be dictated by the policy or plan."

State Medicaid

Kentucky (Source: [Kentucky Revised Statutes](#))

Molina Healthcare, Inc. confidential and proprietary © 2023

This document contains confidential and proprietary information of Molina Healthcare and cannot be reproduced, distributed, or printed without written permission from Molina Healthcare. This page contains prescription brand name drugs that are trademarks or registered trademarks of pharmaceutical manufacturers that are not affiliated with Molina Healthcare.

Drug and Biologic Coverage Criteria

KY304.17A-167 Time span of authorizations

(Subsection 2) “Unless otherwise provided in subsection (3) of this section or prohibited by state or federal law, if a provider receives a prior authorization for a drug prescribed to a covered person with a condition that requires ongoing medication therapy, and the provider continues to prescribe the drug, and the drug is used for a condition that is within the scope of use approved by the United States Food and Drug Administration or has been proven to be a safe and effective form of treatment for the patient’s specific underlying condition based on clinical practice guidelines that are developed from peer-reviewed publications, the prior authorization received shall: (a) Be valid for the lesser of: 1. One (1) year from the date the provider receives the prior authorization; or 2. Until the last day of coverage under the covered person’s health benefit plan during a single plan year; and (b) Cover any change in dosage prescribed by the provider during the period of authorization.” (Subsection 3) “Except as provided in paragraph (b) of this subsection, the provisions of subsection (2) of this section shall not apply to: 1. Medications that are prescribed for a non-maintenance condition; 2. Medications that have a typical treatment period of less than twelve (12) months; 3. Medications where there is medical or scientific evidence that does not support a twelve (12) month approval; or 4. Medications that are opioid analgesics or benzodiazepines. (b) Paragraph (a) of this subsection shall not apply to any medication that is prescribed to a patient in a community-based palliative care program.”

Re-authorization (approved authorization previously issued by Molina Healthcare) for maintenance medications within this policy shall be approved for a 12 month duration when request meets policy requirements, unless exceptions noted above have been met.

Mississippi (Source: [Mississippi Legislature](#))

“SECTION 13. Length of approvals. (1) A prior authorization approval shall be valid for the lesser of six (6) months after the date the health care professional or health care provider receives the prior authorization approval or the length of treatment as determined by the patient’s health care professional or the renewal of the policy or plan, and the approval period shall be effective regardless of any changes, including any changes in dosage for a prescription drug prescribed by the health care professional. Notwithstanding the foregoing, a health insurer and an enrollee or his/her health care professional may extend a prior authorization approval for a longer period, by agreement. All dosage increases must be based on established evidentiary standards, and nothing in this section shall prohibit a health insurance issuer from having safety edits in place. This section shall not apply to the prescription of benzodiazepines or Schedule II narcotic drugs, such as opioids.

(2) Nothing in this section shall require a policy or plan to cover any care, treatment, or services for any health condition that the terms of coverage otherwise completely exclude from the policy’s or plan’s covered benefits without regard for whether the care, treatment or services are medically necessary.

SECTION 14. Approvals for chronic conditions. (1) If a health insurance issuer requires a prior authorization for a recurring health care service or maintenance medication for the treatment of a chronic or long-term condition, including, but not limited to, chemotherapy for the treatment of cancer, the approval shall remain valid for the lesser of twelve (12) months from the date the health care professional or health care provider receives the prior authorization approval or the length of the treatment as determined by the patient’s health care professional. Notwithstanding the foregoing, a health insurer and an enrollee or his or her health care professional may extend a prior authorization approval for a longer period, by agreement. This section shall not apply to the prescription of benzodiazepines or Schedule II narcotic drugs, such as opioids.

(2) Nothing in this section shall require a policy or plan to cover any care, treatment or services for any health condition that the terms of coverage otherwise completely exclude from the policy’s or plan’s covered benefits without regard for whether the care, treatment, or services are medically necessary.”

BACKGROUND AND OTHER CONSIDERATIONS

BACKGROUND:

None

Drug and Biologic Coverage Criteria

CONTRAINDICATIONS/EXCLUSIONS/DISCONTINUATION:

All other uses of Iron chelating Agents (Desferal, Exjade, Ferriprox, Jadenu) are considered experimental/investigational and therefore, will follow Molina's Off-Label policy. Contraindications to Desferal (deferioxamine) include: known hypersensitivity to the active substance, patients with severe renal disease or anuria. Contraindications to Ferriprox (deferiprone) include: Hypersensitivity to deferiprone or to any of the excipients in the formulation. Contraindications to Exjade/Jadenu include: an estimated GFR less than 40 mL/min/1.73 m², patients with poor performance status, patients with high-risk MDS, patients with advanced malignancies, patients with platelet counts less than 50 x 10⁹/L, patients with a known hypersensitivity to deferasirox or any component of the requested product, severe (Child-Pugh C) hepatic impairment, use with nephrotoxic drugs.

OTHER SPECIAL CONSIDERATIONS:

Jadenu and Exjade have a Black Box Warning for renal failure, hepatic failure, and gastrointestinal hemorrhage.

Ferriprox has a Black Box Warning for agranulocytosis and neutropenia.

For Exjade and Jadenu: For patients with renal impairment (eGFR 40–60 mL/min/1.73 m²), reduce the starting dose by 50%. Exercise caution in pediatric patients with eGFR between 40 and 60 mL/min/1.73 m².

CODING/BILLING INFORMATION

Note: 1) This list of codes may not be all-inclusive. 2) Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement

HCPCS CODE	DESCRIPTION
J0895	Injection, deferioxamine mesylate, 500mg

AVAILABLE DOSAGE FORMS:

Deferasirox Granules PACK 180MG
Deferasirox Granules PACK 360MG
Deferasirox Granules PACK 90MG
Deferasirox PACK 180MG
Deferasirox PACK 360MG
Deferasirox PACK 90MG
Deferasirox TABS 180MG
Deferasirox TABS 360MG
Deferasirox TABS 90MG
Deferasirox TBSO 125MG
Deferasirox TBSO 250MG
Deferasirox TBSO 500MG
Deferiprone TABS 1000MG
Deferiprone TABS 500MG
Deferoxamine Mesylate SOLR 2GM
Deferoxamine Mesylate SOLR 500MG

Desferal SOLR 500MG
Exjade TBSO 125MG
Exjade TBSO 250MG
Exjade TBSO 500MG
Ferriprox SOLN 100MG/ML
Ferriprox TABS 1000MG
Ferriprox TABS 500MG
Ferriprox Twice-A-Day TABS 1000MG
Jadenu Sprinkle PACK 180MG
Jadenu Sprinkle PACK 360MG
Jadenu Sprinkle PACK 90MG
Jadenu TABS 180MG
Jadenu TABS 360MG
Jadenu TABS 90MG

REFERENCES

1. Ceci A, Mangiarini L, Felisi M, et al. The management of iron chelation therapy: preliminary data from a national registry of thalassaemic patients. *Anemia*. 2011; 2011: 435683. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3123832/?tool=pubmed>. Available from Internet.
2. Ferriprox (deferiprone) [prescribing information]. Cary, NC: Chiesi USA, Inc.; November 2021.
3. Pennell DJ, Udelson JE, Arai AE, et al. Cardiovascular function, and treatment in β thalassaemia major. *Circulation*.2013;128:281-308.
4. Jadenu (deferasirox) [prescribing information]. East Hanover, NJ: Novartis Pharmaceuticals Corporation; July 2020.
5. Exjade [Package Insert]. East Hanover, NJ: Novartis Pharmaceuticals Corporation; July 2020.
6. Desferal [Package Insert]. East Hanover, NJ: Novartis Pharmaceuticals Corporation; September 2022.
7. Brittenham GM. Iron-chelating therapy for transfusional iron overload. *N Engl JMed*. 2011;364(2):146-156. doi:10.1056/NEJMct1004810
8. Taher, A., Musallam, K., & Cappellini, M.-D. (2017). Guidelines for the Management of Non Transfusion Dependent Thalassaemia (NTDT) 2nd Edition. Thalassaemia International Federation. Retrieved from <https://www.thalassaemia.org/wp-content/uploads/2011/09/Guidelines-for-Mgmt-of-NTDT-TIF-2017.pdf>
9. Cappellini, M.D., Farmakis, D., Porter, J., Taher, A. (2021). Guidelines for the Management of Transfusion Dependent Thalassaemia (4th edition – Version 2.0). Thalassaemia International Federation. Retrieved from <https://thalassaemia.org.cy/publications/tif-publications/guidelines-for-the-management-of-transfusion-dependent-thalassaemia-4th-edition-2021-v2/>

Drug and Biologic Coverage Criteria

SUMMARY OF REVIEW/REVISIONS	DATE
REVISION- Notable revisions: Diagnosis Required Medical Information Continuation of Therapy Duration of Therapy Age Restrictions Quantity Route of Administration FDA-Approved Uses Contraindications/Exclusions/Discontinuation Other Special Considerations Available Dosage Forms References	Q3 2023
REVISION- Notable revisions: Diagnosis Required Medical Information Continuation of Therapy References	Q3 2022
Q2 2022 Established tracking in new format	Historical changes on file