STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES
BUREAU FOR MEDICAL SERVICES

Office of Pharmacy Service
Prior Authorization Criteria

Ferriprox® (Deferiprone)

Prior Authorization Request Form

Indicated for the treatment of transfusional iron overload due to thalassemia syndromes when current chelation therapy is inadequate

Criteria for use

1. Documented diagnosis of transfusional iron overload due to thalassemia syndromes**; AND**
2. In order to start therapy, absolute neutrophil count (ANC) must be greater than $1.5x10^9$/L or 1500/mm^3; **AND**
3. Patient has failed or has had an inadequate response to Desferal (deferoxamine) **and** Exjade (deferasirox) as defined by serum ferritin greater than 2,500mcg/L before treatment with Ferriprox **or** patient has been intolerant to or experienced clinically significant adverse effects to Desferal (deferoxamine) or Exjade (deferasirox), such as evidence of cardiac iron overload or iron-induced cardiac dysfunction; **AND**
4. Ferriprox will not be authorized if there is a previous history of agranulocytosis; **AND**
5. Patient must not be pregnant; **AND**
6. Dose must not exceed 33mg/kg three (3) times per day

Initial authorization will be for three (3) months and may be continued per manual review with the following criteria being considered:
• Experienced a 20% or greater decline in serum ferritin within one (1) year of starting therapy.
• If serum ferritin falls and remains below 500mcg/L, the drug should be discontinued temporarily.

References:

1. Ferriprox (package insert). Rockville, MD: ApoPharma USA, Inc; October 2011
2. Deferiprone (Ferriprox); for iron overload. The Medical Letter 2012; 54:1384
3. Olivieri N et al. Long Term Safety and Effectiveness of Iron-Chelation Therapy with Deferiprone for Thalassemia Major. N Engl J Med 1998; 339:417-423.
4. Hoffbrand AV et al. Role of deferiprone in chelation therapy for transfusional iron overload. Blood 2003;102:17-24.

Reviewed and Approved
Drug Utilization Review Board
May 21, 2014