PREMERA HMO

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PHARMACY POLICY – 5.01.613

Oral Iron Chelating Agents

BCBSA Ref. Policy:	8.01.02	
Effective Date:	Mar. 1, 2025	RELATED MEDICAL POLICIES:
Last Revised:	Feb. 24, 2025	None
Replaces:	N/A	

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Introduction

Certain medical conditions may require the regular transfer of blood or blood products from a donor into another person through the vein (transfusions). People who receive regular blood transfusions often have iron that builds up and is deposited into the different organ systems of the body. Over time this can lead to organ damage and/or organ failure. Chelation is a process that removes certain heavy metals from the blood. Iron chelating agents are drugs containing molecules that bind to iron. Iron is then cleared out of the body through urine or feces. This policy describes when oral iron chelating agents may be considered medically necessary.

Note: The Introduction section is for your general knowledge and is not to be taken as policy coverage criteria. The rest of the policy uses specific words and concepts familiar to medical professionals. It is intended for providers. A provider can be a person, such as a doctor, nurse, psychologist, or dentist. A provider also can be a place where medical care is given, like a hospital, clinic, or lab. This policy informs them about when a service may be covered.

Policy Coverage Criteria

Drug	Medical Necessity
Deferasirox, generic	**Generic deferasirox may be considered medically necessary for the treatment of chronic iron overload due to blood transfusions (transfusional hemosiderosis) when the following criteria are met:** • The individual is receiving blood transfusions at regular intervals **AND** • Prior to starting deferasirox, the individual's serum ferritin level is > 1,000 micrograms/liter **AND** • Deferasirox is prescribed by or in consultation with a hematologist **Generic deferasirox may be considered medically necessary for the treatment of chronic iron overload in non-transfusion dependent thalassemia syndromes when the following criteria are met:** • The individual is aged 10 years or older **AND** • Prior to starting deferasirox, the individual's serum ferritin level is > 300 micrograms/liter **AND** • Deferasirox is prescribed by or in consultation with a hematologist
Deferiprone, generic	**Generic deferiprone may be considered medically necessary for the treatment of transfusional iron overload due to thalassemia syndromes when the following criteria are met:** • The individual is aged 3 years or older **AND** • Prior to starting deferiprone, the individual's serum ferritin level was > 2,500 micrograms/liter **AND** • Deferiprone is prescribed by or in consultation with a hematologist **Generic deferiprone may be considered medically necessary for the treatment of chronic iron overload in non-transfusion**

Drug	Medical Necessity
	dependent thalassemia syndromes when the following criteria are met: • The individual is aged 18 years or older **AND** • Prior to starting deferiprone, the individual's serum ferritin level was > 300 micrograms/liter **AND** • Deferiprone is prescribed by or in consultation with a hematologist **Generic deferiprone may be considered medically necessary for the treatment of chronic iron overload in transfusions related to sickle cell disease when the following criteria are met:** • The individual is aged 3 years or older **AND** • Prior to starting deferiprone, the individual's serum ferritin level was > 1,000 micrograms/liter **AND** • Deferiprone is prescribed by or in consultation with a hematologist
Exjade (deferasirox tablet for oral suspension), Jadenu (deferasirox tablet), Jadenu Sprinkle (deferasirox granules)	**Exjade (deferasirox tablet for oral suspension), Jadenu (deferasirox tablet) and Jadenu Sprinkle (deferasirox granules) may be considered medically necessary for the treatment of chronic iron overload due to blood transfusions (transfusional hemosiderosis) when the following criteria are met:** • The individual is receiving blood transfusions at regular intervals **AND** • Prior to starting Exjade, Jadenu, or Jadenu Sprinkle, the individual's serum ferritin level is > 1,000 micrograms/liter **AND** • Exjade, Jadenu, or Jadenu Sprinkle is prescribed by or in consultation with a hematologist **AND**

Drug	Medical Necessity
	• Has tried generic deferasirox and had an inadequate response after 3-months of treatment or had intolerance to generic deferasirox **Exjade (deferasirox tablet for oral suspension), Jadenu (deferasirox tablet) and Jadenu Sprinkle (deferasirox granules) may be considered medically necessary for the treatment of chronic iron overload in non-transfusion dependent thalassemia syndromes when the following criteria are met:** • The individual is aged 10 years or older **AND** • Prior to starting Exjade, Jadenu, or Jadenu Sprinkle, the individual's serum ferritin level is > 300 micrograms/liter **AND** • Exjade, Jadenu, or Jadenu Sprinkle is prescribed by or in consultation with a hematologist **AND** • Has tried generic deferasirox and had an inadequate response after 3-months of treatment or had intolerance to generic deferasirox
Ferriprox (deferiprone)	**Ferriprox (deferiprone) may be considered medically necessary for the treatment of transfusional iron overload due to thalassemia syndromes when the following criteria are met:** • The individual is aged 3 years or older **AND** • Prior to starting Ferriprox, the individual's serum ferritin level was > 2,500 micrograms/liter **AND** • Has tried generic deferiprone and had an inadequate response after 3-months of treatment or had intolerance to generic deferiprone **AND** • Ferriprox is prescribed by or in consultation with a hematologist **Ferriprox (deferiprone) may be considered medically necessary for the treatment of chronic iron overload in non-transfusion**

Drug	Medical Necessity
	dependent thalassemia syndromes when the following criteria are met: • The individual is aged 18 years or older **AND** • Prior to starting Ferriprox, the individual's serum ferritin level was > 300 micrograms/liter **AND** • Has tried generic deferiprone and had an inadequate response after 3-months of treatment or had intolerance to generic deferiprone **AND** • Ferriprox is prescribed by or in consultation with a hematologist **Ferriprox (deferiprone) may be considered medically necessary for the treatment of chronic iron overload in transfusions related to sickle cell disease when the following criteria are met:** • The individual is aged 3 years or older **AND** • Prior to starting Ferriprox, the individual's serum ferritin level was > 1,000 micrograms/liter **AND** • Has tried generic deferiprone and had an inadequate response after 3-months of treatment or had intolerance to generic deferiprone **AND** • Ferriprox is prescribed by or in consultation with a hematologist

Drug	Investigational
As listed	**The medications listed in this policy are subject to the product's US Food and Drug Administration (FDA) dosage and administration prescribing information.**

Drug	Investigational
	All other uses of the medications for conditions not outlined in this policy are considered investigational.

Length of Approval	
Approval	**Criteria**
Initial authorization	**Non-formulary exception reviews and all other reviews for drugs listed in this policy may be approved up to 12 months.**
Re-authorization criteria	**Non-formulary exception reviews and all other reviews for drugs listed in this policy may be approved up to 12 months when:** • The drug-specific coverage criteria are met **AND** • Chart notes document a reduction in serum ferritin levels below baseline.

Documentation Requirements
The individual's medical records submitted for review for all conditions should document that medical necessity criteria are met. The record should include the following: • Office visit notes that contain the diagnosis, serum ferritin levels, medication history and documentation the drug is prescribed by or in consultation with a hematologist.

Coding

N/A

Related Information

Consideration of Age

The ages stated in this policy for which Exjade (deferasirox tablet for oral suspension), Ferriprox (deferiprone), generic deferasirox, generic deferiprone, Jadenu (deferasirox tablet) and Jadenu Sprinkle (deferasirox granules) are considered medically necessary are based on the ages approved in the FDA labeling.

Benefit Application

This policy is managed through the pharmacy benefit.

Evidence Review

Background

Iron chelating therapy should be considered in all individuals who require long-term blood transfusions. Individuals with sickle cell disease, myelodysplastic syndromes (MDS), thalassemia major, Diamond-Blackfan anemia, aplastic anemia, and other congenital and acquired forms of refractory anemia (e.g., hereditary hemochromatosis) may require regular blood transfusions and as a result may require iron chelation therapy. This is because the body does not have an efficient mechanism to excrete iron. In individuals requiring multiple blood transfusions, iron accumulates and is deposited into multiple organ systems. The long-term consequences of chronic iron overload include multiple organ dysfunction (e.g., heart, liver) and/or organ failure. Iron chelation therapy is necessary to prevent organ failure and decrease mortality. In the US, it is estimated that approximately 25,000 individuals are transfusion dependent due to various causes such as sickle cell disease and refractory anemias.

Serum ferritin level measurements are the laboratory parameter most often used to assess the iron burden and response to chelation therapy. Sustained serum ferritin levels > 2,500 mcg/L are associated with organ toxicity and death. Most chelation regimens strive to achieve the goal of ferritin levels < 2,500 mcg/L. Trends in ferritin level are useful in monitoring the direction of body iron loading, but it may not predict cardiac iron loading. Long-term elevations in ferritin levels predict cardiac mortality, with ferritin levels > 2,500 mcg/L indicating a higher cardiac risk; however, there is no threshold effect, so a ferritin level of 1,000 mcg/L could indicate a risk. Cardiac iron levels have a better predictive value of heart failure.

Summary of Evidence

Exjade (deferasirox tablet for oral suspension), Jadenu (deferasirox tablet) and Jadenu Sprinkle (deferasirox granules)

Chronic Iron Overload Due to Blood Transfusions

The primary efficacy study, Study 1, was a multicenter, open-label, randomized, active comparator control study to compare deferasirox and deferoxamine in individuals with beta-thalassemia and transfusional hemosiderosis. Individuals greater than or equal to 2 years of age were randomized in a 1:1 ratio to receive either oral deferasirox at starting doses of 5, 10, 20, or 30 mg per kg once daily or subcutaneous deferoxamine at starting doses of 20 to 60 mg per kg for at least 5 days per week based on liver iron (Fe) concentration (LIC) at baseline (2-3, greater than 3-7, greater than 7-14, and greater than 14mg Fe/g dry weight). Individuals randomized to deferoxamine who had LIC values less than 7mg Fe/g dry weight were permitted to continue on their prior deferoxamine dose, even though the dose may have been higher than specified in the protocol.

Individuals were to have a liver biopsy at baseline and end of study (after 12 months) for LIC. The primary efficacy endpoint was defined as a reduction in LIC of greater than or equal to 3mg Fe/g dry weight for baseline values greater than or equal to 10mg Fe/g dry weight, reduction of baseline values between 7 and less than 10 to less than 7mg Fe/g dry weight, or maintenance or reduction for baseline values less than 7mg Fe/g dry weight. A total of 586 individuals were randomized and treated, 296 with deferasirox and 290 with deferoxamine. The mean age was 17.1 years (range, 2-53 years); 52% were females and 88% were Caucasian. The primary efficacy population consisted of 553 individuals (deferasirox n = 276; deferoxamine n = 277) who had LIC evaluated at baseline and 12 months or discontinued due to an adverse event. The percentage of individuals achieving the primary endpoint was 52.9% for deferasirox and 66.4% for deferoxamine. The relative efficacy of deferasirox to deferoxamine cannot be determined from this study. In individuals who had an LIC at baseline and at end of study, the mean change in LIC was -2.4 mg Fe/g dry weight in individuals treated with deferasirox and -2.9 mg Fe/g dry weight in individuals treated with deferoxamine. Reduction of LIC and serum ferritin was observed with deferasirox doses of 20 to 30mg per kg per day. Deferasirox doses below 20mg per kg per day failed to provide consistent lowering of LIC and serum ferritin levels. Therefore, a starting dose of 20mg per kg per day is recommended.

Study 2 was an open-label, non-comparative trial of efficacy and safety of deferasirox given for 1 year to individuals with chronic anemias and transfusional hemosiderosis. Similar to Study 1,

individuals received 5, 10, 20, or 30 mg per kg per day of deferasirox based on baseline LIC. A total of 184 individuals were treated in this study: 85 individuals with beta-thalassemia and 99 individuals with other congenital or acquired anemias (myelodysplastic syndromes, n = 47; Diamond-Blackfan syndrome, n = 30; other, n = 22). Nineteen percent (19%) of individuals were less than 16 years of age and 16% were greater than 65 years of age. There was a reduction in the absolute LIC from baseline to end of study (-4.2 mg Fe/g dry weight). Study 3 was a multicenter, open-label, randomized trial of the safety and efficacy of deferasirox relative to deferoxamine given for 1 year in individuals with sickle cell disease and transfusional hemosiderosis. Individuals were randomized to deferasirox at doses of 5, 10, 20, or 30 mg per kg per day or subcutaneous deferoxamine at doses of 20-60 mg per kg per day for 5 days per week according to baseline LIC. A total of 195 individuals were treated in this study: 132 with deferasirox and 63 with deferoxamine. Forty-four percent (44%) of individuals were less than 16 years of age and 91% were black. At end of study, the mean change in LIC in the per protocol-1 (PP-1) population, which consisted of individuals who had at least 1 post-baseline LIC assessment, was -1.3 mg Fe/g dry weight for individuals receiving deferasirox (n = 113) and -0.7mg Fe/g dry weight for individuals receiving deferoxamine (n = 54). One-hundred five (105) individuals with thalassemia major and cardiac iron overload were enrolled in a study assessing the change in cardiac MRI T2* value (measured in milliseconds, ms) before and after treatment with deferasirox. Cardiac T2* values at baseline ranged from 5 to less than 20 ms. The geometric mean of cardiac T2* in the 68 individuals who completed 3 years of deferasirox therapy increased from 11.98 ms at baseline to 17.12 ms at 3 years. Cardiac T2* values improved in individuals with severe cardiac iron overload (less than 10 ms) and in those with mild to moderate cardiac iron overload (greater than or equal to 10 to less than 20 ms). The clinical significance of these observations is unknown. Six hundred twenty-seven (627) individuals with MDS were enrolled across 5 uncontrolled trials. Two hundred thirty-nine(239) of the 627 individuals were enrolled in trials that limited enrollment to individuals with IPSS Low or Intermediate 1 risk MDS, and the remaining 388 individuals were enrolled in trials that did not specify MDS risk stratification but required a life expectancy of greater than 1 year. Planned duration of treatment in these trials ranged from 1 year (365 individuals) to 5 years (47 individuals). These trials evaluated the effects of deferasirox therapy on parameters of iron overload, including LIC (125 individuals) and serum ferritin (627 individuals). The percent of individuals completing planned duration of treatment was 51% in the largest 1-year study, 52% in the 3-year study and 22% in the 5-year study. The major causes for treatment discontinuation were withdrawal of consent, adverse reaction, and death. Over 1 year of follow-up across these pooled studies, mean change in serum ferritin was -332.8 (±2615.59) mcg/L (n = 593) and mean change in LIC was -5.9 (±8.32) mg Fe/g dw (n = 68). Results of these pooled studies in 627 individuals with MDS suggest a progressive decrease in serum ferritin and LIC beyond 1 year in those individuals who are able to continue deferasirox. Study 4 was a randomized, double-blind,

placebo-controlled trial performed in 225 individuals with MDS (Low/Int-1 risk) and transfusional iron overload of which 149 were treated with deferasirox and 76 received placebo. The observed hazard ratio of 0.64 (95% CI: 0.42, 0.96) suggests a positive impact of deferasirox on event-free survival (EFS, a composite endpoint defined as death, worsening cardiac function, hospitalization for congestive heart failure, liver function impairment, liver cirrhosis, or progression to acute myeloid leukemia, whichever occurred first).

Chronic Iron Overload in Non-Transfusion Dependent Thalassemia Syndromes

Study 5 was a randomized, double-blind, placebo-controlled trial of treatment with deferasirox for individuals 10 years of age or older with non-transfusion dependent thalassemia (NTDT) syndromes and iron overload. Eligible individuals had an LIC of at least 5 mg Fe/g dw measured by R2 MRI and a serum ferritin exceeding 300 mcg/L at screening (2 consecutive values at least 14 days apart from each other). A total of 166 individuals were randomized, 55 to the deferasirox 5 mg/kg/day dose group, 55 to the deferasirox 10 mg/kg/day dose group, and 56 to placebo (28 to each matching placebo group). Doses could be increased after 6 months if the LIC exceeded 7 mg Fe/g dw and the LIC reduction from baseline was less than 15%. The individuals enrolled included 89 males and 77 females. The underlying disease was beta-thalassemia intermedia in 95 (57%) individuals, HbE beta-thalassemia in 49 (30%) individuals, and alpha-thalassemia in 22 (13%) individuals. There were 17 pediatric individuals in the study. Caucasians comprised 57% of the study population and Asians comprised 42%. The median baseline LIC (range) for all individuals was 12.1 (2.6-49.1) mg Fe/g dw. Follow-up was for 1 year. The primary efficacy endpoint of change in LIC from baseline to Week 52 was statistically significant in favor of both deferasirox dose groups compared with placebo ($p \leq 0.001$). Furthermore, a statistically significant dose effect of deferasirox was observed in favor of the 10 mg/kg/day dose group (10 versus 5 mg/kg/day, $p = 0.009$). In a descriptive analysis, the target LIC (less than 5 mg Fe/g dw) was reached by 15 (27%) of 55 individuals in the 10 mg/kg/day arm, 8 (15%) of 55 individuals in the 5 mg/kg/day arm and 2 (4%) of 56 individuals in the combined placebo groups.

Study 6 was an open-label trial of deferasirox for the treatment of individuals previously enrolled on Study 5, including cross-over to active treatment for those previously treated with placebo. The starting dose of deferasirox in Study 6 was assigned based on the individual's LIC at completion of Study 5, being 20 mg/kg/day for an LIC exceeding 15 mg Fe/g dw, 10 mg/kg/day for LIC 3-15 mg Fe/g dw, and observation if the LIC was less than 3 mg Fe/g dw. Individuals could continue on 5 mg/kg/day if they had previously exhibited at least a 30% reduction in LIC. Doses could be increased to a maximum of 20 mg/kg/day after 6 months if the LIC was more than 7 mg Fe/g dw and the LIC reduction from baseline was less than 15%. The primary efficacy

endpoint in Study 6 was the proportion of individuals achieving an LIC less than 5 mg Fe/g dw. A total of 133 individuals were enrolled. Twenty individuals began Study 6 with an LIC less than 5 mg Fe/g dw. Of the 113 individuals with a baseline LIC of at least 5 mg Fe/g dw in Study 6, the target LIC (less than 5 mg Fe/g dw) was reached by 39 (35%). The responders included 4 (10%) of 39 individuals treated at 20 mg/kg/day for a baseline LIC exceeding 15 mg Fe/g dw, and 31 (51%) of 61 individuals treated at 10 mg/kg/day for a baseline LIC between 5 and 15 mg Fe/g dw.

Safety

For transfusional iron overload a total of 700 adult and pediatric individuals were treated with deferasirox for 48 weeks in premarketing studies. The discontinuation rate across studies in the first year was 46% (AEs 20%, withdrawal of consent 10%, death 8%, other 4%, lab abnormalities 3%, and lack of efficacy 1%). The adverse reactions occurring in greater than 5% of deferasirox-treated individuals were abdominal pain, nausea, vomiting, diarrhea, skin rashes, and increases in serum creatinine were the most frequent AEs reported with a suspected relationship to deferasirox. Gastrointestinal symptoms, increases in serum creatinine, and skin rash were dose related.

Ferriprox (deferiprone)

Transfusional Iron Overload Due to Thalassemia Syndromes

In a prospective, planned, pooled analysis of individuals from several studies, the efficacy of deferiprone was assessed in transfusion dependent iron overload individuals in whom previous iron chelation therapy had failed or was considered inadequate due to poor tolerance. The main criterion for chelation failure was serum ferritin > 2,500 mcg/L before treatment with deferiprone. Deferiprone therapy (35-99 mg/kg/day) was considered successful in individual individuals who experienced a ≥ 20% decline in serum ferritin within one year of starting therapy. Data from a total of 236 individuals were analyzed. Of the 224 individuals with thalassemia who received deferiprone monotherapy and were eligible for serum ferritin analysis, 105 (47%) were male and 119 (53%) were female. The mean age of these individuals was 18.2 years. For the individuals in the analysis, the endpoint of at least a 20% reduction in serum ferritin was met in 50% (of 236 subjects), with a 95% confidence interval of 43% to 57%. A small number of individuals with thalassemia and iron overload were assessed by measuring the change in the number of milliseconds (ms) in the cardiac MRI T2* value before and after

treatment with deferiprone for one year. There was an increase in cardiac MRI T2* from a mean at baseline of 11.8 ± 4.9 ms to a mean of 15.1 ± 7.0 ms after approximately one year of treatment. The clinical significance of this observation is not known.

Chronic Iron Overload in Non-Transfusion Dependent Thalassemia Syndromes

Iron overload in thalassemia intermedia is mainly due to increased intestinal absorption of iron due to chronic anemia. Transfusions play a minor role in iron overloading in these individuals, but iron chelation therapy is indicated for thalassemia intermedia. A 5-year randomized, open-label, long-term trial was conducted in individuals (n = 88) with thalassemia intermedia comparing deferiprone with deferoxamine IV treatment. After 5 years there were no statistically significant differences between deferiprone and deferoxamine in the decrease in mean serum ferritin levels and overall survival. There are data available from other studies as well with deferiprone use in chronic iron overload in non-transfusion dependent thalassemia syndromes.

Chronic Iron Overload in Transfusions Related to Sickle Cell Disease

A 5-year multicenter, randomized, open-label trial assessed the efficacy of deferiprone compared with deferoxamine intravenous (IV) treatment in individuals with sickle cell disease. Individuals (n = 60) were > 13 years of age and had serum ferritin concentration between 800 to 3,000 mcg/L. By Year 5, 36.6% of individuals treated with deferiprone achieved serum ferritin levels < 400 mcg/L compared with 3.3% of individuals treated with deferoxamine (P = 0.002). Overall survival did not differ significantly between the two groups after 5 years or 10 years.

Safety

Adverse event (AE) information for deferiprone represents the pooled data collected from 642 individuals who participated in single arm or active-controlled clinical trials. The most serious adverse reaction reported in clinical trials with deferiprone was agranulocytosis. The most common AE's that occurred in greater than 5% of deferiprone treated individuals in were nausea (13%), vomiting (10%), abdominal pain (10%), arthralgia (10%), alanine aminotransferase increased (7%), and neutropenia (5%).

2020 Update

Reviewed prescribing information for all drugs in policy and conducted a literature search from October 1, 2019 through September 30, 2020. Based on literature review and supported by a physician board certified in pediatric hematology-oncology the lower age limit of 2 years was removed from generic deferasirox, Exjade (deferasirox tablet for oral suspension), Jadenu (deferasirox tablet), and Jadenu Sprinkle (deferasirox granules) when being used for the treatment of chronic iron overload due to blood transfusions (transfusional hemosiderosis).

2021 Update

Reviewed prescribing information for all drugs in policy. Updated policy criteria for Ferriprox (deferiprone) and generic deferiprone from 18 years of age and older to 8 years of age and older for the treatment of transfusional iron overload in individuals with thalassemia syndromes and individuals with sickle cell disease. The prescribing information updated in April 2021 documents that the safety and effectiveness has been established in pediatric individuals 8 years of age and older for these two conditions.

2022 Update

Reviewed prescribing information for all drugs in policy. No new information was identified that would require changes to this policy.

2023 Update

Reviewed prescribing information for all drugs in policy. No new information was identified that would require changes to this policy.

2024 Update

Reviewed prescribing information for all drugs in policy. Updated Ferriprox (deferiprone) coverage criteria to require trial with generic deferiprone.

2025 Update

Reviewed prescribing information for all drugs in policy. Clarified that non-formulary exception review authorizations for all drugs listed in this policy may be approved up to 12 months. Clarified that the medications listed in this policy are subject to the product's FDA dosage and administration prescribing information.

References

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History

Date	Comments
10/01/19	New policy, approved September 10, 2019. Add to Prescription Drug section. Criteria added for generic deferasirox, Exjade (deferasirox tablet for oral suspension), Ferriprox (deferiprone), Jadenu (deferasirox tablet) and Jadenu Sprinkle (deferasirox granules).
12/01/20	Annual Review, approved November 3, 2020. Removed the lower age limit of 2 years from generic deferasirox, Exjade (deferasirox tablet for oral suspension), Jadenu (deferasirox tablet), and Jadenu Sprinkle (deferasirox granules) when being used for the treatment of chronic iron overload due to blood transfusions (transfusional hemosiderosis).
02/01/21	Interim Review, approved January 6, 2021. Added generic deferiprone to policy with identical coverage criteria as Ferriprox (deferiprone).
06/01/21	Annual Review, approved May 20, 2021. Updated policy criteria for Ferriprox (deferiprone) and generic deferiprone from 18 years of age and older to 8 years of age and older for the treatment of transfusional iron overload in patients with thalassemia syndromes and patients with sickle cell disease.
01/01/22	Interim Review, approved December 21, 2021. Updated policy criteria for Ferriprox (deferiprone) and generic deferiprone from 8 years of age and older to 3 years of age and older for the treatment of transfusional iron overload in patients with thalassemia syndromes and patients with sickle cell disease.
01/01/23	Annual Review, approved December 12, 2022. No changes to policy statements. Changed the wording from "patient" to "individual" throughout the policy for standardization.
07/01/23	Annual Review, approved June 26, 2023. No changes to the policy statements.
04/01/24	Annual Review, approved March 12, 2024. Updated Ferriprox (deferiprone) coverage criteria to require trial with generic deferiprone.
03/01/25	Annual Review, approved February 24, 2025. Clarified that non-formulary exception review authorizations for all drugs listed in this policy may be approved up to 12 months. Clarified that the medications listed in this policy are subject to the product's FDA dosage and administration prescribing information.

Scope: Medical policies are systematically developed guidelines that serve as a resource for Company staff when determining coverage for specific medical procedures, drugs or devices. Coverage for medical services is subject to the limits and conditions of the member benefit plan. Members and their providers should consult the member

benefit booklet or contact a customer service representative to determine whether there are any benefit limitations applicable to this service or supply. This medical policy does not apply to Medicare Advantage.