

Clinical Policy: Iron Chelating Agents

Reference Number: PHW.PDL.727

Effective Date: 01/01/2020

Last Review Date: 11/2024

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 PA Health & Wellness® that Iron Chelating Agents are **medically necessary** when the following criteria are met:

I. Requirements for Prior Authorization of Iron Chelating Agents

A. Prescriptions That Require Prior Authorization

All prescriptions for Iron Chelating Agents must be prior authorized.

B. Review of Documentation for Medical Necessity

In evaluating a request for prior authorization of a prescription for an Iron Chelating Agent, the determination of whether the requested prescription is medically necessary will take into account whether the member:

1. Is being treated for a diagnosis that is indicated in the U.S. Food and Drug Administration (FDA)-approved package labeling OR a medically accepted indication; **AND**
2. Is age-appropriate according to FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature; **AND**
3. Is prescribed a dose and duration of therapy that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature; **AND**
4. Is prescribed the Iron Chelating Agent by or in consultation with a specialist (i.e., hematologist); **AND**
5. Has documentation of baseline lab results as recommended in the FDA-approved package labeling; **AND**
6. Does not have a history of a contraindication to the prescribed medication; **AND**
7. For a non-preferred Iron Chelating Agent, has documented therapeutic failure, contraindication, or intolerance of the preferred Iron Chelating Agents approved or medically accepted for the member's diagnosis.

NOTE: If the member does not meet the clinical review guidelines listed above but, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the member, the request for prior authorization will be approved.

FOR RENEWALS OF PRIOR AUTHORIZATION FOR IRON CHELATING AGENTS: The determination of medical necessity of a request for renewal of a prior authorization for an Iron Chelating Agent that was previously approved will take into account whether the member:

1. Has documentation of tolerability and a positive clinical response to the medication; **AND**
2. Is prescribed the Iron Chelating Agent by or in consultation with a specialist (i.e. hematologist); **AND**
3. Has documentation of results of recent lab monitoring as recommended in the FDA-approved package labeling; **AND**
4. Is prescribed a dose and duration of therapy that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature; **AND**
5. Is continuing treatment with the prescribed Iron Chelating Agent based on recent lab results as recommended in the FDA-approved package labeling.

NOTE: If the member does not meet the clinical review guidelines listed above but, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the member, the request for prior authorization will be approved.

C. Clinical Review Process

Prior authorization personnel will review the request for prior authorization and apply the clinical guidelines in Section B. above to assess the medical necessity of a prescription for an Iron Chelating Agent. If the guidelines in Section B. are met, the reviewer will prior authorize the prescription. If the guidelines are not met, the prior authorization request will be referred to a physician reviewer for a medical necessity determination. Such a request for prior authorization will be approved when, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the member.

D. Approval Duration:

- **New Request: 6 months**
- **Renewal Request: 12 months**

E. References

1. Exjade [Package Insert]. East Hanover, NJ. Novartis. December 2018.
2. Jadenu [Package Insert]. East Hanover, NJ. Novartis. December 2018.
3. Ferriprox [Package Insert]. Weston, FL. ApoPharma USA, Inc. May 2017.
4. Taher, A et al. Guidelines for the management of non transfusion dependent thalassaemia: 2nd Edition. 2017. <https://www.thalassemia.org/boduw/wp-content/uploads/2011/09/Guidelines-for-Mgmt-of-NTDT-TIF-2017.pdf>. Accessed April 20, 2019.

Reviews, Revisions, and Approvals	Date
Policy created	01/01/2020
Q3 2020 annual review: no changes.	07/2020
Q1 2021 annual review: no changes.	01/2021
Q1 2022 annual review: no changes.	11/2021
Q1 2023 annual review: no changes.	11/2022
Q1 2024 annual review: no changes.	11/2023
Q1 2025 annual review: no changes.	11/2024