

Clinical Policy: Deferasirox (Exjade, Jadenu)

Reference Number: IL.PHAR.145

Effective Date: 1.1.20

Last Review Date: 04.10.23

Line of Business: Medicaid

[Revision Log](#)

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

Description

Deferasirox (Exjade[®], Jadenu[®]) is an iron chelator.

FDA Approved Indication(s)

Exjade and Jadenu are indicated for the treatment of:

- Chronic iron overload due to blood transfusions (transfusional hemosiderosis) in patients 2 years of age and older.
- Chronic iron overload in patients 10 years of age and older with non-transfusion-dependent thalassemia (NTDT) syndromes and with a liver iron concentration (LIC) of at least 5 milligrams of iron per gram of liver dry weight (mg Fe/g dw) and a serum ferritin greater than 300 mcg/L. This indication is based on achievement of an LIC less than 5 mg Fe/g dw. An improvement in survival or disease-related symptoms has not been established.

Limitation(s) of use:

- Controlled clinical trials of Exjade/Jadenu with myelodysplastic syndromes (MDS) and chronic iron overload due to blood transfusions have not been performed.
- The safety and efficacy of Exjade/Jadenu when administered with other iron chelation therapy have not been established.

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 Exjade and Jadenu are **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Chronic Iron Overload due to Blood Transfusions (must meet all):

1. Diagnosis of chronic iron overload due to blood transfusions;
2. Age \geq 2 years;
3. Member must use generic deferasirox, unless contraindicated or clinically significant adverse effects are experienced;
4. 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;
5. At the time of the request, member has none of the following contraindications:
 - a. Glomerular filtration rate (GFR) $<$ 40 mL/min/1.73 m²;
 - b. Platelet count $<$ 50 x 10⁹/L;

- c. Severe hepatic impairment (Child-Pugh C);
6. Therapy does not include concurrent use of other iron chelators;
7. Dose does not exceed the following (a or b):
 - a. Exjade: 40 mg/kg per day;
 - b. Jadenu: 28 mg/kg per day.

Approval duration: 6 months

B. Chronic Iron Overload due to Non-Transfusion Dependent Thalassemia Syndromes (must meet all):

1. Diagnosis of chronic iron overload due to NTDT;
2. Age \geq 10 years;
3. Member must use generic deferasirox, unless contraindicated or clinically significant adverse effects are experienced;
4. Documentation of serum ferritin level $>$ 300 mcg/L and a LIC \geq 5 mg Fe/g dw;
5. Therapy does not include concurrent use of other iron chelators;
6. At the time of the request, member has none of the following contraindications:
 - a. GFR $<$ 40 mL/min/1.73 m²;
 - b. Platelet count $<$ 50 x 10⁹/L;
 - c. Severe hepatic impairment (Child-Pugh C);
7. Dose does not exceed the following (a or b):
 - a. Exjade: 20 mg/kg per day;
 - b. Jadenu: 14 mg/kg per day.

Approval duration: 6 months

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

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
 - a. For drugs on the formulary PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.PMN.255 for Medicaid; or
 - b. For drugs NOT on the PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.PMN.16 for Medicaid; or
- C. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.PMN.53 for Medicaid

II. Continued Therapy

A. Chronic Iron Overload due to Blood Transfusions (must meet all):

1. Member meets one of the following (a or b):
 - a. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
 - b. Member is currently receiving medication and is enrolled in a state and product with continuity of care regulations (*refer to state specific addendums for CC.PHARM.03A and CC.PHARM.03B*);

2. Current documentation (within the past 30 days) shows a serum ferritin level ≥ 500 mcg/L;
3. Therapy does not include concurrent use of other iron chelators;
4. If request is for a dose increase, new dose does not exceed the following (a or b):
 - a. Exjade: 40 mg/kg per day;
 - b. Jadenu: 28 mg/kg per day.

Approval duration: 12 months

B. Chronic Iron Overload due to Non Transfusion-Dependent Thalassemia Syndromes
(must meet all):

1. Member meets one of the following (a or b):
 - a. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
 - b. Member is currently receiving medication and is enrolled in a state and product with continuity of care regulations (*refer to state specific addendums for CC.PHARM.03A and CC.PHARM.03B*);
2. Current documentation (serum ferritin within past 30 days; LIC within past 90 days) shows one of the following (a or b):
 - 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;
 - b. If member has received ≥ 6 months of Exjade/Jadenu, an LIC is ≥ 3 mg Fe/g dw;
3. Therapy does not include concurrent use of other iron chelators;
4. If request is for a dose increase, new dose does not exceed the following (a or b):
 - a. Exjade: 20 mg/kg per day;
 - b. Jadenu: 14 mg/kg per day.

Approval duration: 12 months

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

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
 - a. For drugs on the PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.PMN.255 for Medicaid; or
 - b. For drugs NOT on the formulary PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: 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.PMN.53 for Medicaid or evidence of coverage documents.
- B. Parkinson's Disease

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

FDA: Food and Drug Administration
Fe/g dw: iron in milligrams per gram dry weight

GFR: glomerular filtration rate
LIC: liver iron concentration
NTDT: non-transfusion-dependent thalassemia

Appendix B: Therapeutic Alternatives

Not applicable

Appendix C: Contraindications/Boxed Warnings

- Contraindication(s):
 - Estimated GFR < 40 mL/min/1.73 m²
 - Poor performance status
 - High-risk myelodysplastic syndromes
 - Advanced malignancies
 - Platelet count < 50 x 10⁹/L
 - Known hypersensitivity to deferasirox or any component of Exjade or Jadenu
- Boxed warning(s):
 - Acute liver injury, including acute renal failure requiring dialysis and renal tubular toxicity including Fanconi syndrome
 - Hepatic toxicity, including failure
 - Gastrointestinal hemorrhage
 - Therapy requires close patient monitoring, including laboratory tests of renal and hepatic function.

Appendix D: General Information

- In FAIRPARK-II, deferiprone, an iron chelator, was associated with worse scores in measures of parkinsonism compared to placebo over a 36-week period in participants with newly diagnosed Parkinson’s disease who had never received levodopa.

V. Dosage and Administration

Drug Name	Indication	Dosing Regimen	Maximum Dose
Deferasirox (Exjade)	Transfusional iron overload	20 mg/kg body weight (calculate dose to the nearest whole tablet) PO QD	40 mg/kg/day
	NTDT syndromes	10 mg/kg body weight (calculate dose to the nearest whole tablet) PO QD	20 mg/kg/day
Deferasirox (Jadenu)	Transfusional iron overload	14 mg/kg body weight (calculated to nearest whole tablet/sachet) PO QD	28 mg/kg/day
	NTDT syndromes	7 mg/kg body weight (calculated to nearest whole tablet/sachet) PO QD	14 mg/kg/day

VI. Product Availability

Drug	Availability
Deferasirox (Exjade)	Tablets for oral suspension: 125 mg, 250 mg, 500 mg
Deferasirox (Jadenu)	Tablets/sprinkle (sachets): 90 mg, 180 mg, 360 mg

VII. References

1. Exjade Prescribing Information. East Hanover, NJ: Novartis Pharmaceuticals Corporation; July 2020. Available at <https://www.pharma.us.novartis.com/sites/www.pharma.us.novartis.com/files/exjade.pdf>. Accessed May 13, 2021.
2. Jadenu Prescribing Information. East Hanover, NJ: Novartis Pharmaceuticals Corporation; July 2020. Available at <https://www.pharma.us.novartis.com/sites/www.pharma.us.novartis.com/files/jadenu.pdf>. Accessed May 13, 2021.
3. 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.
4. Hoffbrand AV, Taher A, Cappellini MD. How I treat transfusional iron overload. *Blood.* November 1, 2012; 120(18): 3657-3669.
5. Taher AT, Viprakasit V, Musallam KM, Cappellini MD. Treating iron overload in patients with non-transfusion-dependent thalassemia: Critical Review. *Am J Hematol.* 2013; 88: 409-415. DOI: 10.1002/ajh.23405.
6. Taher A, Musallam K, Cappellini MD. Guidelines for the management of non-transfusion dependent thalassaemia (NTDT) 2nd edition. Thalassaemia International Federation. 2018. TIF publication No. 22.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
New policy created, adapted CP.PHAR.145 Deferasirox (Exjade, Jadenu) policy.	12.9.19	1.7.20
3Q 2020 Annual Review: Added - If request is for Exjade, Jadenu, or Jadenu Sprinkle, medical justification supports inability to use generic deferasirox (e.g., contraindications to excipients);	9/15/20	
3Q 2021 annual review: no significant changes; revised medical justification language for not using generic deferasirox; references reviewed and updated.	9.8.21	
Template changes applied to other diagnoses/indications and continued therapy section	11.1.22	
Added Parkinson disease to section III with rationale in Appendix D.	4.10.23	

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.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

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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