

Effective Date: 12/01/2021
Reviewed: 09/2021, 5/2022, 4/2023, 5/2024, 5/2025
Scope: Medicaid

Accrufer (Ferric Maltol)

POLICY

I. CRITERIA FOR APPROVAL

An authorization of 6 months may be granted when all the following criteria are met:

- A. Patient is 18 years or older; AND
- B. Patient has documented diagnosis of iron deficiency; AND
- C. Patient has iron-deficiency anemia with a Hemoglobin (Hb) ≤ 11 g/dL; AND
 - a. Ferritin ≤ 100 ng/mL; AND
 - b. Transferrin saturation (TSAT) $< 20\%$
- D. The patient has experienced a failure, contraindication, or intolerance to at least two oral iron products (e.g., ferrous gluconate, ferrous sulfate).

II. CONTINUATION OF THERAPY

Refer to initial criteria.

III. QUANTITY LIMIT

- 2 capsules per day or 60 capsules per 30 days

IV. COVERAGE DURATION

- 6 months