Effective Date: 12/01/2021
Reviewed: 09/2021, 5/2022, 4/2023, 5/2024, 5/2025, 3/2026 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. Member is 10 years or older; AND
B. Member has documented diagnosis of iron deficiency; AND
C. Member 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 member 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

V. REFERENCES

1. Accrufer Prescribing Information. London: Shield Therapeutics; December 2025.