



## Reblozyl® (luspatercept-aamt) (Subcutaneous)

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### I. Length of Authorization <sup>1</sup>

- Beta Thalassemia: Coverage will be provided initially for 15 weeks (5 initial doses) and may be renewed annually thereafter.
- Myelodysplastic Syndrome: Coverage will be provided initially for 21 weeks (7 initial doses) and may be renewed every 6 months thereafter.

### II. Dosing Limits

#### A. Quantity Limit (max daily dose) [NDC Unit]:

- Reblozyl 25 mg single-dose vial: 2 vials every 21 days
- Reblozyl 75 mg single-dose vial: 2 vials every 21 days

#### B. Max Units (per dose and over time) [HPCS Unit]:

- Beta Thalassemia: 600 billable units every 21 days
- Myelodysplastic Syndrome: 800 billable units every 21 days

### III. Initial Approval Criteria <sup>1</sup>

Coverage is provided in the following conditions:

- Patient is at least 18 years of age, unless otherwise specified\*\*; AND

#### Universal Criteria <sup>1</sup>

- Females of reproductive potential have a negative pregnancy test prior to start of therapy and will use an effective method of contraception during treatment and for at least 3 months after treatment; AND
- Patient has not had a deep vein thrombosis or a thrombotic stroke which required medical intervention within 6 months prior to therapy; AND
- Other causes of anemia (e.g., hemolysis, bleeding, recent major surgery, vitamin deficiency, etc.) have been ruled out; AND

- Reblozyl is not being used as a substitute for RBC transfusions in patients requiring immediate correction of anemia; **AND**
- Patient has a baseline Hemoglobin (Hb) < 11.5 g/dL (if Hb is 11.5 g/dL or higher, the dose must be delayed until the Hb is 11 g/dL or less) (***Note:** If an RBC transfusion occurred prior to dosing, the pretransfusion Hgb must be considered for dosing purposes. Lab values are obtained within 7 days of the date of administration*); **AND**

#### **Beta Thalassemia † Φ<sup>1,4,8</sup>**

- Patient has a documented diagnosis of beta thalassemia (excludes alpha-thalassemia and hemoglobin S/β-thalassemia variants) as outlined by the following:
  - Patient diagnosis is confirmed by *HBB* sequence gene analysis showing biallelic pathogenic variants; **OR**
  - Patient has severe microcytic hypochromic anemia, anisopoikilocytosis with nucleated red blood cells on peripheral blood smear, and hemoglobin analysis that reveals decreased amounts or complete absence of hemoglobin A and increased amounts of hemoglobin F; **AND**
- Patient is red blood cell (RBC) transfusion dependent as defined by requiring 6-20 RBC units per 24 weeks; **AND**
- Patient does not have major end organ damage§, defined as any of the following:
  - Liver disease with an ALT > 3x the ULN or history of evidence of cirrhosis; **OR**
  - Heart disease, heart failure NYHA classification 3 or higher, or significant arrhythmia requiring treatment, or recent myocardial infarction within 6 months of treatment; **OR**
  - Lung disease, including pulmonary fibrosis or pulmonary hypertension which are clinically significant i.e., ≥ Grade 3; **OR**
  - Creatinine clearance < 60 mL/min

*§Requests for patients deemed to have any major end organ damage will be reviewed on a case-by-case basis.*

*\*\*Requests for patients <18 years will be considered on a case by case basis for those with high transfusion burden and symptomatic iron overload, history of alloimmunization, or history of transfusion reactions*

#### **Myelodysplastic Syndrome † ‡ Φ<sup>1,5-7</sup>**

- Patient has required 2 or more red blood cell units over an 8 week timeframe; **AND**
- Patient has a diagnosis of one of the following:
  - Myelodysplastic syndrome with ring sideroblasts (MDS-RS); **OR**
  - Myelodysplastic/myeloproliferative neoplasm with ring sideroblasts and thrombocytosis (MDS/MPN-RS-T); **AND**
- Patient has lower risk disease (IPSS-R very low, low, or intermediate-risk); **AND**

- Patient has symptomatic anemia with ring sideroblasts  $\geq 15\%$  (or ring sideroblasts  $\geq 5\%$  with an SF3B1 mutation); **AND**
  - Serum erythropoietin  $>200$  mU/mL; **OR**
  - Patient has had an inadequate response to prior treatment with an ESA (i.e. epoetin alpha  $\geq 40,000$  units/week for at least 8 doses or darbepoetin alpha  $\geq 500$  mcg every 3 weeks for at least 4 doses); **OR**
  - Patient has a documented contraindication or intolerance to the use of an erythropoiesis-stimulating agent

† FDA approved indications; ‡ Compendia Recommended Indication(s);  $\Phi$  Orphan Drug

#### IV. **Renewal Criteria** <sup>1,5-8</sup>

- Patient continues to meet universal and other indication-specific relevant criteria such as concomitant therapy requirements (not including prerequisite therapy), performance status, etc. identified in section III; **AND**
- Patient will not receive doses  $< 21$  days apart; **AND**
- Absence of unacceptable toxicity from the drug. Examples of unacceptable toxicity include: thromboembolic events, severe hypertension, extramedullary hematopoietic masses in patients with beta thalassemia, etc.; **AND**

##### **Beta Thalassemia**

- Patient is experiencing disease response as evidenced by a decrease in the number of RBC transfusions; **OR**
- For new starts: Patient has not achieved a reduction in RBC transfusion burden after at least 2 consecutive, initial (1 mg/kg) doses (6 weeks) and requires a dose increase to 1.25 mg/kg; **OR**
- Patient experienced a response followed by a lack/loss of response and requires a dose increase to 1.25 mg/kg (from 1 mg/kg)

##### **Myelodysplastic Syndrome**

- Patient is experiencing disease response as evidenced by a decrease in the number of RBC transfusions; **OR**
- For new starts: Patient has not achieved a reduction in RBC transfusion burden after at least 2 consecutive, initial (1 mg/kg) doses (6 weeks) and requires a dose increase to 1.33 mg/kg; **OR**
- Patient has not achieved a reduction in RBC transfusion burden after at least 2 consecutive, 1.33 mg/kg doses (6 weeks) and requires a dose increase to 1.75 mg/kg; **OR**
- Patient experienced a response followed by a lack/loss of response and requires a dose increase by one dose level from the level in which response was lost (not to exceed a dose of 1.75 mg/kg)

**\*Note:** Discontinue Reblozyl if a patient does not experience a decrease in transfusion burden after 9 weeks of treatment (administration of 3 doses) at the maximum dose level or if unacceptable toxicity occurs at any time.

## V. Dosage/Administration <sup>1</sup>

Indication	Dose
Beta Thalassemia	<p>The recommended starting dose is 1 mg/kg once every 3 weeks by subcutaneous injection.</p> <ul style="list-style-type: none"> <li><u>Dose increases for insufficient response:</u> If a patient does not achieve a reduction in RBC transfusion burden after at least 2 consecutive doses (6 weeks) at the 1 mg/kg starting dose, increase the Reblozyl dose to 1.25 mg/kg. Do not increase the dose beyond the maximum dose of 1.25 mg/kg.</li> </ul>
Myelodysplastic Syndrome	<p>The recommended starting dose is 1 mg/kg once every 3 weeks by subcutaneous injection.</p> <ul style="list-style-type: none"> <li><u>Dose increases for insufficient response:</u> If a patient is not RBC transfusion free after at least 2 consecutive doses (6 weeks) at the 1 mg/kg starting dose, increase the Reblozyl dose to 1.33 mg/kg. If a patient is not RBC transfusion free after at least 2 consecutive doses (6 weeks) at the 1.33 mg/kg starting dose, increase the Reblozyl dose to 1.75 mg/kg. Do not increase the dose beyond the maximum dose of 1.75 mg/kg.</li> </ul> <p><i><u>Note:</u> If, upon a dose modification (i.e., dose reduction), a patient loses response (i.e. requires a transfusion) or Hgb concentration drops by 1 g/dL or more in 3 weeks in the absence of transfusion, increase the dose by one dose level. Wait a minimum of 6 weeks between dose increases.</i></p>
<ul style="list-style-type: none"> <li>If a planned administration of Reblozyl is delayed or missed, administer Reblozyl as soon as possible and continue dosing as prescribed, with at least 3 weeks between doses.</li> <li>Assess and review hemoglobin (Hgb) results prior to each administration. If an RBC transfusion occurred prior to dosing, the pretransfusion Hgb must be considered for dosing purposes.</li> <li><u>Dose decreases/interruptions:</u> If Hgb increase is &gt;2 g/dL or the pre-dose Hgb is <math>\geq 11.5</math> g/dL and the Hgb level is not influenced by recent transfusion, reduce the dose or interrupt treatment until the Hgb is <math>\leq 11</math> g/dL.</li> <li>Reblozyl should be reconstituted and administered by a healthcare professional.</li> </ul>	

## VI. Billing Code/Availability Information

### HCPCS Code:

- J0896 – Injection, luspatercept-aamt, 0.25 mg: 1 billable unit = 0.25 mg

### NDC:

- Reblozyl 25 mg single-dose vial: 59572-0711-xx
- Reblozyl 75 mg single-dose vial: 59572-0775-xx

## VII. References

- Reblozyl [package insert]. Summit, NJ; Celgene, Inc: September 2022. Accessed March 2023.
- Cappellini MD, Viprakasit V, Taher A, et al. The Believe trial: results of a phase 3, randomized, double-blind, placebo-controlled study of luspatercept in adult beta-thalassemia patients who require regular red blood cell (RBC) transfusions. Abstract #163. Presented at the 2018 ASH Annual Meeting, December 1, 2018; San Diego, CA.

3. Galanello R and Origa R. Beta-thalassemia. *Orphanet J Rare Dis*. 2010 May 21;5:11. Available at: <https://ojrd.biomedcentral.com/articles/10.1186/1750-1172-5-11>. Accessed November 2019.
4. Origa R. Beta-Thalassemia. 2000 Sep 28 [Updated 2021 Feb 4]. GeneReviews® [Internet]. Seattle (WA): University of Washington, Seattle; 1993-2023. Available from: <https://www.ncbi.nlm.nih.gov/books/NBK1426/>. Accessed March 2023.
5. Referenced with permission from the NCCN Drugs & Biologics Compendium (NCCN Compendium®) luspatercept-aamt. National Comprehensive Cancer Network, 2023. The NCCN Compendium® is a derivative work of the NCCN Guidelines®. NATIONAL COMPREHENSIVE CANCER NETWORK®, NCCN®, and NCCN GUIDELINES® are trademarks owned by the National Comprehensive Cancer Network, Inc. To view the most recent and complete version of the Compendium, go online to NCCN.org. Accessed March 2023.
6. Referenced with permission from the NCCN Drugs & Biologics Compendium (NCCN Compendium®) Myelodysplastic Syndromes. Version 1.2023. National Comprehensive Cancer Network, 2023. The NCCN Compendium® is a derivative work of the NCCN Guidelines®. NATIONAL COMPREHENSIVE CANCER NETWORK®, NCCN®, and NCCN GUIDELINES® are trademarks owned by the National Comprehensive Cancer Network, Inc. To view the most recent and complete version of the Compendium, go online to NCCN.org. Accessed March 2023.
7. Fenaux P, Platzbecker U, Mufti GJ, et al. Luspatercept in Patients with Lower-Risk Myelodysplastic Syndromes. January 9, 2020. *N Engl J Med* 2020; 382:140-151 DOI: 10.1056/NEJMoa1908892.
8. Cappellini MD, Viprakasit V, Taher AT, et al. A Phase 3 Trial of Luspatercept in Patients With Transfusion-Dependent  $\beta$ -Thalassemia. *N Engl J Med*, 382 (13), 1219-1231; 2020 Mar 26. PMID: 32212518. DOI: [10.1056/NEJMoa1910182](https://doi.org/10.1056/NEJMoa1910182).
9. Beaudoin FL, Richardson M, Synnott PG, et al. Betibeglogene Autotemcel for Beta Thalassemia: Effectiveness and Value; Final Evidence Report. Institute for Clinical and Economic Review, July 19, 2022. [https://icer.org/wp-content/uploads/2021/11/ICER\\_Beta-Thalassemia\\_Final-Report\\_071922.pdf](https://icer.org/wp-content/uploads/2021/11/ICER_Beta-Thalassemia_Final-Report_071922.pdf).

## Appendix 1 – Covered Diagnosis Codes

ICD-10	ICD-10 Description
C93.10	Chronic myelomonocytic leukemia not having achieved remission
D46.0	Refractory anemia without ring sideroblasts, so stated
D46.1	Refractory anemia with ring sideroblasts
D46.20	Refractory anemia with excess of blasts, unspecified
D46.21	Refractory anemia with excess of blasts 1
D46.4	Refractory anemia, unspecified

### REBLOZYL® (luspatercept-aamt) - Prior Auth Criteria

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D46.9	Myelodysplastic syndrome, unspecified
D46.A	Refractory cytopenia with multilineage dysplasia
D46.B	Refractory cytopenia with multilineage dysplasia and ring sideroblasts
D46.Z	Other myelodysplastic syndromes
D56.1	Beta thalassemia

## Appendix 2 – Centers for Medicare and Medicaid Services (CMS)

Medicare coverage for outpatient (Part B) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals. In addition, National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) may exist and compliance with these policies is required where applicable. They can be found at:

<https://www.cms.gov/medicare-coverage-database/search.aspx>. Additional indications may be covered at the discretion of the health plan.

Medicare Part B Covered Diagnosis Codes (applicable to existing NCD/LCD/LCA): N/A

Medicare Part B Administrative Contractor (MAC) Jurisdictions		
Jurisdiction	Applicable State/US Territory	Contractor
E (1)	CA, HI, NV, AS, GU, CNMI	Noridian Healthcare Solutions, LLC
F (2 & 3)	AK, WA, OR, ID, ND, SD, MT, WY, UT, AZ	Noridian Healthcare Solutions, LLC
5	KS, NE, IA, MO	Wisconsin Physicians Service Insurance Corp (WPS)
6	MN, WI, IL	National Government Services, Inc. (NGS)
H (4 & 7)	LA, AR, MS, TX, OK, CO, NM	Novitas Solutions, Inc.
8	MI, IN	Wisconsin Physicians Service Insurance Corp (WPS)
N (9)	FL, PR, VI	First Coast Service Options, Inc.
J (10)	TN, GA, AL	Palmetto GBA, LLC
M (11)	NC, SC, WV, VA (excluding below)	Palmetto GBA, LLC
L (12)	DE, MD, PA, NJ, DC (includes Arlington & Fairfax counties and the city of Alexandria in VA)	Novitas Solutions, Inc.
K (13 & 14)	NY, CT, MA, RI, VT, ME, NH	National Government Services, Inc. (NGS)
15	KY, OH	CGS Administrators, LLC



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- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

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Grievance Specialist  
PreferredOne Community Health Plan  
PO Box 59052  
Minneapolis, MN 55459-0052  
Phone: 1.800.940.5049 (TTY: 763.847.4013)  
Fax: 763.847.4010  
[customerservice@preferredone.com](mailto:customerservice@preferredone.com)

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, a Grievance Specialist is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services  
200 Independence Avenue, SW  
Room 509F, HHH Building  
Washington, D.C. 20201  
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

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LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1.800.940.5049 (TTY: 763.847.4013).

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, taiaaajila gargaarsa afaanij, kanfaltiidhaan ala, ni argama. Bilbilaa 1.800.940.5049 (TTY: 763.847.4013).

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ဟ်သ့ဟ်သး- နမၤကတိၤ ကသီၤ ကျိၣ်အယိၤ, နမၤန့ၣ် ကျိၣ်အတၢ်မၤစၢၤလၢ တလၢၣ်ဘျဉ်လၢၣ်စၢၤ နီၣ်တမံၤဘၣ်သ့န့ၣ်လီၤ. ကိး 1.800.940.5049 (TTY: 763.847.4013).

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Minneapolis, MN 55459-0212  
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Fax: 763.847.4010  
[customerservice@preferredone.com](mailto:customerservice@preferredone.com)

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You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services  
200 Independence Avenue, SW  
Room 509F, HHH Building  
Washington, D.C. 20201  
1-800-368-1019, 800-537-7697 (TDD)

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ဟံသာဝတီ: နမူနာတို့ ကညီ ကျိအသိ, နမူနာ ကျိအတိအကျတို့ တလက်ကွက်လက်စွာ နှိတ်ခံဘက်သို့လွှဲလိ။ ကိ: 1.800.940.5049 (TTY: 763.847.4013).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1.800.940.5049 (TTY: 763.847.4013).

ប្រយ័ត្ន: បើសិនជាអ្នកនិយាយភាសាខ្មែរ, សេវាជំនួយភាសា ដោយមិនគិតថ្លៃ គឺអាចមានសំរាប់អ្នក។ ហៅ 1.800.940.5049 (TTY: 763.847.4013).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1.800.940.5049 (رقم هاتف الصم والبكم: 763.847.4013).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1.800.940.5049 (TTY: 763.847.4013).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1.800.940.5049 (TTY: 763.847.4013). 번으로 전화해 주십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1.800.940.5049 (TTY: 763.847.4013).