Reference number(s)
4717-A

STANDARD MEDICARE PART B MANAGEMENT

REBLOZYL (luspatercept-aamt)

POLICY

I. INDICATIONS

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

A. FDA-Approved Indications

1. Treatment of anemia in adult patients with beta thalassemia who require regular red blood cell (RBC) transfusions
2. Treatment of anemia failing an erythropoiesis stimulating agent and requiring 2 or more red blood cell units over 8 weeks in adult patients with very low- to intermediate- risk myelodysplastic syndromes with ring sideroblasts (MDS-RS) or with myelodysplastic/myeloproliferative neoplasm with ring sideroblasts and thrombocytosis (MDS/MPN-RS-T)

Limitations of Use: Reblozyl is not indicated for use as a substitute for red blood cell (RBC) transfusions in patients who require immediate correction of anemia.

All other indications will be assessed on an individual basis. Submissions for indications other than those enumerated in this policy should be accompanied by supporting evidence from Medicare approved compendia.

II. DOCUMENTATION

A. Anemia with Beta Thalassemia

The following documentation must be available, upon request, for all submissions:

1. Initial therapy requests:
   i. Pretreatment or pretransfusion hemoglobin (Hgb) level
   ii. Hemoglobin electrophoresis or high-performance liquid chromatography (HPLC) results OR molecular genetic testing results

B. Anemia of Myelodysplastic Syndrome or Myelodysplastic/Myeloproliferative Neoplasm

The following documentation must be available, upon request, for all submissions:

1. Initial therapy requests:
   i. Pretreatment or pretransfusion hemoglobin (Hgb) level
   ii. Pretreatment ring sideroblasts level
   iii. *SF3B1* mutation status (if pretreatment ring sideroblasts are greater than or equal to 5% and less than 15%)
   iv. Pretreatment serum erythropoietin levels

III. EXCLUSIONS

Coverage will not be provided for the treatment of anemia with beta thalassemia in members with hemoglobin S/β-thalassemia or alpha-thalassemia.

IV. CRITERIA FOR INITIAL APPROVAL

A. Anemia with Beta Thalassemia
Authorization of 16 weeks may be granted for treatment of anemia with beta thalassemia in patients 18 years of age or older when all of the following criteria are met:
1. The member has symptomatic anemia evidenced by a pretreatment or pretransfusion Hgb level less than or equal to 11 g/dL (grams per deciliter)
2. The member has a diagnosis of beta thalassemia (β-thalassemia) or hemoglobin E/β-thalassemia (β-thalassemia with mutation and/or multiplication of alpha globin is allowed) confirmed by one of the following:
    i. Hemoglobin electrophoresis or high-performance liquid chromatography (HPLC)
    ii. Molecular genetic testing
3. The member required at least 6 red blood cell (RBC) units to be transfused in the previous 24 weeks

Note: If a red blood cell (RBC) transfusion occurred prior to dosing, the pretransfusion hemoglobin (Hgb) level must be considered for dosing purposes.

B. **Anemia of Myelodysplastic Syndrome or Myelodysplastic/Myeloproliferative Neoplasm**
Authorization of 24 weeks may be granted for the treatment of very low- to intermediate-risk myelodysplastic syndrome or myelodysplastic/myeloproliferative neoplasm in patients 18 years of age or older when all of the following criteria are met:
1. The member has symptomatic anemia evidenced by a pretreatment or pretransfusion Hgb level less than or equal to 11 g/dL
2. The member has been receiving regular red blood cell (RBC) transfusions as defined by greater than or equal to 2 units per 8 weeks
3. The member meets either of the following:
    i. Ring sideroblasts are greater than or equal to 15%
    ii. Ring sideroblasts are greater than or equal to 5% and the member has an SF3B1 mutation
4. The member meets either of the following:
    i. Pretreatment serum erythropoietin levels greater than 500 mIU/mL (milli-International Unit per milliliter)
    ii. Pretreatment serum erythropoietin levels less than or equal to 500 mIU/mL following no response to the combination of an erythropoiesis-stimulating agent (ESA) and granulocyte-colony stimulating factor (G-CSF)

V. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must be currently receiving therapy with the requested agent.

Authorization for 6 months may be granted when all of the following criteria are met:
A. The member is currently receiving therapy with Reblozyl

B. Reblozyl is being used to treat an indication enumerated in Section IV
C. The member is receiving benefit from therapy. Benefit is defined as meeting all of the following criteria:
   1. Achieving or maintaining red blood cell transfusion burden reduction
   2. No evidence of unacceptable toxicity from Reblozyl

VI. REFERENCES

1. Reblozyl [package insert]. Summit, NJ: Celgene Corporation, a Bristol-Myers Squibb Company; July 2022.
2. Capellini MD, Viprakasit V, Taher AT, et al. A Phase 3 Trial of Luspatercept in Patients with Transfusion-Dependent β-Thalassemia. N Engl J Med 2020;382:1219-31.
3. Benz EJ. Clinical manifestations and diagnosis of the thalassemias. UpToDate [online serial]. Waltham, MA: UpToDate; reviewed July 2022.
4. National Comprehensive Cancer Network. The NCCN Drugs & Biologics Compendium. http://www.nccn.org. Accessed July 21, 2022.
5. Fenaux P., Platzbecker U, Mufti GJ, et.al. Luspatercept in Patients with Lower-Risk Myelodysplastic Syndromes. N Engl J Med 2020;382:140-51.