Harvard Pilgrim Health Care | TUFTS Health Plan

Medical Necessity Guidelines
Medical Benefit Drugs
Reblozyl® (luspatercept-aamt)

Effective: April 1, 2025

Guideline Type	☒ Prior Authorization ☐ Non-Formulary ☐ Step-Therapy ☐ Administrative

Applies to:
Commercial Products
☐ Harvard Pilgrim Health Care Commercial products; Fax 617-673-0988
☐ Tufts Health Plan Commercial products; Fax 617-673-0988
CareLink℠ – Refer to CareLink Procedures, Services and Items Requiring Prior Authorization

Public Plans Products
☐ Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product); Fax 617-673-0988
☐ Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans; Fax 617-673-0939
☐ Tufts Health RITogether – A Rhode Island Medicaid Plan; Fax 617-673-0939
☒ Tufts Health One Care* – A Medicare-Medicaid Plan (a dual eligible product); Fax 617-673-0956
*The MNG applies to Tufts Health One Care members unless a less restrictive LCD or NCD exists.

Senior Products
☒ Tufts Health Plan Senior Care Options (SCO), (a dual-eligible product); Fax 617-673-0956
☒ Tufts Medicare Preferred HMO, (a Medicare Advantage product); Fax 617-673-0956
☒ Tufts Medicare Preferred PPO, (a Medicare Advantage product); Fax 617-673-0956

Note: While you may not be the provider responsible for obtaining prior authorization, as a condition of payment you will need to ensure that prior authorization has been obtained.

Overview

Approval of **Reblozyl (luspatercept-aamt)** for treatment of anemia in adults with beta thalassemia who require regular blood transfusions (RBC) was based on the BELIEVE trial. The primary endpoint of the proportion of patients achieving RBC transfusion burden reduction from baseline of at least 33%, with a reduction of at least 2 units from Week 13 to eek 24, was achieved in 21.4% of Reblozyl-treated patients compared to 4.5% of placebo-treated patients. Furthermore, the proportion of patients achieving at least a 50% reduction from baseline in red blood cell transfusion burden with a reduction of at least 2 units for 12 consecutive weeks was higher with Reblozyl (7.6% vs 18%). Patients were included in the BELIEVE trial if they required regular red blood cell transfusions defined as 6 to 20 red blood cell units per 24 weeks, with no transfusion-free period greater than 35 days during that period.

Approval of Reblozyl for the treatment of anemia in myelodysplastic/myeloproliferative neoplasm with ring sideroblasts and thrombocytosis was based on the MEDALIST trial. The MEDALIST trial evaluated the safety and efficacy of Reblozyl compared to placebo in patients with Revised International Prognostic Scoring System very low-, low-, or intermediate-risk disease with chronic anemia and who are refractory to, intolerant of, or ineligible for treatment with an erythropoiesis-stimulating agent, ring sideroblast–positive and require frequent red blood cell transfusions. The primary endpoint was red blood cell transfusion independence (RBC-TI) for at least 8 weeks between Week 1 and Week 24. Secondary endpoints included RBC-TI for at least 12 weeks between Week 1 and Week 24, and between Week 1 and Week 48 and achievement of modified hematologic improvement-erythroid response for any consecutive 56-day period (assessed using International Working Group 2006 criteria). Results demonstrated that 37.9% of Reblozyl-treated patients met the primary endpoint compared to 13.2% of placebo-treated patients. Results also favored Reblozyl for the secondary endpoints as well (RBC-TI for at least 12 weeks; 28.1% vs 7.9%, mHI-E response; 52.9% vs 11.8%).

Approval of Reblozyl for the treatment of anemia in adults with very low- to intermediate-risk myelodysplastic syndrome who require regular red blood cell transfusions and who are ESA-naïve was based on the COMMANDS trial. Results demonstrated superior efficacy of concurrent RBC-TI and hemoglobin increase compared to epoetin alfa regardless of ring sideroblast status.

Specifically, 58.5% of Reblozyl-treated patients achieved the primary endpoint of RBC-TI of at least 12 weeks with a mean hemoglobin increase of at least 1.5 g/dL within the first 24 weeks compared to 31.2% of epoetin alfa-treated patients (p<0.0001).

Food and Drug Administration - Approved Indications

Reblozyl (luspatercept-aamt) is an erythroid maturation agent indicated for the treatment of:

- **Beta Thalassemia**
  Anemia in adult patients with beta thalassemia who require regular blood cell transfusions
- **Myelodysplastic Syndromes Associated Anemia**
  Anemia without previous erythropoiesis stimulating agent (ESA) use (ESA-naïve) in adult patients with very low- to intermediate-risk myelodysplastic syndromes who may require regular blood cell transfusions
- **Myelodysplastic syndromes with ring sideroblasts (MDS-RS) or myelodysplastic/myeloproliferative neoplasm with ring sideroblasts (MDS/MPN-RST) and thrombocytosis associated anemia**
  Anemia failing an ESA and requiring 2 or more red blood cell units over eight 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).

Reblozyl is not indicated for use as a substitute for red blood cell transfusions in patients who require immediate correction of anemia.

Clinical Guideline Coverage Criteria

The plan may authorize coverage of Reblozyl for Members when **ALL** of the following criteria are met:

Beta Thalassemia

Initial Authorization Criteria:

1. Documented diagnosis of beta thalassemia

AND

2. Prescribed by or in consultation with a hematologist

AND

3. Documentation the patient requires regular red blood cell transfusions

AND

4. Patient is at least 18 years of age or older

Reauthorization Criteria:

1. Documented diagnosis of beta thalassemia

AND

2. Prescribed by or in consultation with a hematologist

AND

3. Documentation of a reduction in transfusion requirements from pretreatment baseline

AND

4. Patient is at least 18 years of age or older

Myelodysplastic Syndromes

Initial Authorization Criteria:

1. Documented diagnosis of **one (1)** of the following:
   a. Myelodysplastic syndrome
   b. Myelodysplastic/myeloproliferative neoplasm with ring sideroblasts and thrombocytosis

AND

2. Documentation of very low to intermediate-risk disease

AND

3. Documentation the patient has required **two (2)** or more red blood cell units over an **eight (8)** week timeframe

AND

4. If the patient has myelodysplastic/myeloproliferative neoplasm with ring sideroblasts and thrombocytosis, documentation of **one (1)** of the following:
   a. Inadequate response to an erythropoiesis stimulating agent

b. Clinical inappropriateness to treatment with an erythropoiesis stimulating agent

AND

5. Patient is at least 18 years of age or older

AND

6. Prescribed by or in consultation with a hematologist or oncologist

Reauthorization Criteria

1. Documented diagnosis of very low- to intermediate-risk myelodysplastic syndromes

AND

2. Patient is at least 18 years of age or older

AND

3. Prescribed by or in consultation with a hematologist or oncologist

AND

4. Documentation that the Member has experienced a therapeutic response as defined by the provider indicating a decrease in the need for red blood cell transfusions

Limitations

- Initial approval of Reblozyl will be limited to six (6) months. Reauthorization of Reblozyl will be provided in 12-month intervals.
- Members new to the plan and stable on Reblozyl should be reviewed against Reauthorization Criteria

Codes

The following code(s) require prior authorization:

Table 1: HCPCS Codes

HCPCS Codes	Description
J0896	Injection, luspatercept-aamt, 0.25 mg

References

1. Reblozyl (luspatercept-aamt) [prescribing information]. South San Francisco, CA: Genentech, Inc.; May 2024.
2. Cappellini MD, et al. A phase 3 trial of luspatercept in patients with transfusion-dependent β-thalassemia. N Engl J Med. 2020;382:1219-31. 3.
3. Langhi D, et al. Guidelines on Beta-thalassemia major - regular blood transfusion therapy: Associação Brasileira de Hematologia, Hemoterapia e Terapia Celular: project guidelines: Associação Médica Brasileira – 2016. Rev Bras Hematol Hemater. 2016 Oct-Dec;38(4):341-5.
4. Farmakis D, et al. 2021 Thalassaemia International Federation Guidelines for the Management of Transfusion-dependent Thalassemia. Hemasphere. 2022 Aug;6(8):e732.
5. NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®) for Myelodysplastic Syndromes V.3.2023. National Comprehensive Cancer Network, Inc. 2023. Accessed January 23, 2024. NCCN.org

Approval And Revision History

May 17, 2023: Reviewed by the Medical Policy Approval Committee (MPAC).

June 13, 2023: Reviewed by Pharmacy and Therapeutics Committee (P&T).

Subsequent endorsement date(s) and changes made:

- Originally approved September 13, 2022, by P&T and September 21, 2022 by MPAC committees effective January 1, 2023.
- Administrative update: April 2023 added Medical Benefit Drugs to title, updated MATogether and RITogether fax numbers to 617-673-0939.
- May 17, 2023: Annual review, no change, effective July 1, 2023.
- August 2023: Administrative update to rebrand Tufts Health Unify to Tufts Health One Care for 2024.
- November 2023: Administrative Update in support of calendar year 2024 Medicare Advantage and PDP Final Rule.
- February 13, 2024: Minor wording updates. Administrative update to check off Harvard Pilgrim Health Care Stride

business line. Added coverage criteria for the supplemental indication of myelodysplastic syndromes associated anemia to the Medical Necessity Guideline (effective 3/1/2024).

- March 11, 2025: No changes. Administrative update to remove Harvard Pilgrim Health Care Stride Medicare Advantage from the Medical Necessity Guideline template (eff 4/1/25)
- March 2025: Joint Medical Policy and Health Care Services UM Committee review (eff 4/1/25).

Background, Product and Disclaimer Information

Point32Health prior authorization criteria to be applied to Medicare Advantage plan members is based on guidance from Medicare laws, National Coverage Determinations (NCDs) or Local Coverage Determinations (LCDs). When no guidance is provided, Point32Health uses clinical practice guidance published by relevant medical societies, relevant medical literature, Food and Drug Administration (FDA)-approved package labeling, and drug compendia to develop prior authorization criteria to apply to Medicare Advantage plan members. Medications that require prior authorization generally meet one or more of the following criteria: Drug product has the potential to be used for cosmetic purposes; drug product is not considered as first-line treatment by medically accepted practice guidelines, evidence to support the safety and efficacy of a drug product is poor, or drug product has the potential to be used for indications outside of the indications approved by the FDA. Prior authorization and use of the coverage criteria within this Medical Necessity Guideline will ensure drug therapy is medically necessary, clinically appropriate, and aligns with evidence-based guidelines. We revise and update Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests revisions.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of this guidelines not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to eligibility and benefits on the date of service, coordination of benefits, referral/authorization, utilization management guidelines when applicable, and adherence to plan policies, plan procedures, and claims editing logic.