Drug Policy:

Reblozyl™ (luspatercept-aamt)

POLICY NUMBER UM ONC_1392	SUBJECT Reblozyl™ (luspatercept-aamt)		DEPT/PROGRAM UM Dept	PAGE 1 OF 3
DATES COMMITTEE REVIEWED 04/08/20, 08/12/20, 11/11/20, 10/13/21, 11/15/21	APPROVAL DATE November 15, 2021	EFFECTIVE DATE November 29, 2021	COMMITTEE APPROVAL DATES 04/08/20, 08/12/20, 11/11/20, 10/13/21, 11/15/21	
PRIMARY BUSINESS OWNER: UM		COMMITTEE/BOARD APPROVAL Utilization Management Committee		
URAC STANDARDS HUM 1	NCQA STANDARDS UM 2		ADDITIONAL AREAS OF IMPACT	
CMS REQUIREMENTS	STATE/FEDERAL REQUIREMENTS		APPLICABLE LINES OF BUSINESS Commercial, Exchange, Medicaid	

I. PURPOSE

To define and describe the accepted indications for Reblozyl (luspatercept-aamt) usage in the treatment of cancer, including FDA approved indications, and off-label indications.

New Century Health (NCH) is responsible for processing all medication requests from network ordering providers. Medications not authorized by NCH may be deemed as not approvable and therefore not reimbursable.

The use of this drug must be supported by one of the following: FDA approved product labeling, CMS-approved compendia, National Comprehensive Cancer Network (NCCN), American Society of Clinical Oncology (ASCO) clinical guidelines, or peer-reviewed literature that meets the requirements of the CMS Medicare Benefit Policy Manual Chapter 15.

II. INDICATIONS FOR USE/INCLUSION CRITERIA

A. PREFERRED MEDICATION GUIDANCE FOR INITIAL REQUEST:

1. When health plan Medicaid coverage provisions—including any applicable PDLs (Preferred Drug Lists)—conflict with the coverage provisions in this drug policy, health plan Medicaid coverage provisions take precedence per the Preferred Drug Guidelines OR
2. When health plan Exchange coverage provisions-including any applicable PDLs (Preferred Drug Lists)-conflict with the coverage provisions in this drug policy, health plan Exchange coverage provisions take precedence per the Preferred Drug Guidelines OR

3. For Health Plans that utilize NCH UM Oncology Clinical Policies as the initial clinical criteria, the Preferred Drug Guidelines shall follow NCH L1 Pathways when applicable, otherwise shall follow NCH drug policies AND
4. Continuation requests of previously approved, non-preferred medication are not subject to this provision AND
5. When applicable, generic alternatives are preferred over brand-name drugs.

B. Myelodysplastic Syndromes (MDS)

1. Reblozyl (luspatercept-aamt) is being used for ALL of the following conditions:
   a. Member has Lower Risk MDS with symptomatic anemia, specifically either MDS with ring sideroblasts ≥ 15% OR MDS with ring sideroblasts ≥ 5% + SF3B1 mutation AND
   b. Serum erythropoietin level > 500 mU/ml OR
   c. Serum erythropoietin level < 500 mU/ml AND failure of a trial of therapy (generally 3-6 months) with an ESA- Erythropiesis Stimulating Agent (epoetin alfa ≥ 40,000 IU/week or darbepoetin alpha ≥ 500 mcg/3 weeks) AND the member required 2 or more RBC units over 8 weeks.
   d. TREATMENT DISCONTINUATION: Reblozyl should be discontinued if the member has an inadequate response to a therapeutic trial: Less than 1 gm/dl increase in Hgb and/or the member is still transfusion dependent (defined as requiring a prbc transfusion every 8 weeks after 24 weeks of therapy and/or requiring a red blood cell transfusion every 12 weeks after 48 weeks of therapy).

C. Beta Thalassemia Anemia

1. Reblozyl (luspatercept-aamt) is being used for ALL of the following conditions:
   a. The member has beta thalassemia anemia who require regular red blood cell (RBC) transfusions defined as 6-20 RBC units within the last 6 months, including the last 30 days
   b. Initiate if hemoglobin (Hgb) is ≤ 11 gm/dL
   c. Continue if Hgb is ≤ 11 gm/dL OR transfusion burden is not reduced after at least 2 consecutive doses
   d. Discontinue if there is an increase in RBC transfusion burden after 3 doses (9 weeks) at the maximum dose (1.25 mg/kg) or if unacceptable toxicity occurs.

III. EXCLUSION CRITERIA

A. Concurrent use with an erythropoiesis-stimulating agent, cytotoxic agents, or immunosuppressants.

B. Dosing exceeds single dose limit of Reblozyl (luspatercept-aamt) 1.25 mg/kg for Beta Thalassemia Anemia and 1.75 mg/kg for MDS.

C. Investigational use of Reblozyl (luspatercept-aamt) with an off-label indication that is not sufficient in evidence or is not generally accepted by the medical community. Sufficient evidence that is not supported by CMS recognized compendia or acceptable peer reviewed literature is defined as any of the following:

1. Whether the clinical characteristics of the patient and the cancer are adequately represented in the published evidence.

2. Whether the administered chemotherapy/biologic therapy/immune therapy/targeted therapy/other oncologic therapy regimen is adequately represented in the published evidence.
3. Whether the reported study outcomes represent clinically meaningful outcomes experienced by patients. Generally, the definition of Clinically Meaningful outcomes are those recommended by ASCO, e.g., Hazard Ratio of < 0.80 and the recommended survival benefit for OS and PFS should be at least 3 months.
4. Whether the experimental design, in light of the drugs and conditions under investigation, is appropriate to address the investigative question. (For example, in some clinical studies, it may be unnecessary or not feasible to use randomization, double blind trials, placebos, or crossover).
5. That non-randomized clinical trials with a significant number of subjects may be a basis for supportive clinical evidence for determining accepted uses of drugs.
6. That case reports are generally considered uncontrolled and anecdotal information and do not provide adequate supportive clinical evidence for determining accepted uses of drugs.
7. That abstracts (including meeting abstracts) without the full article from the approved peer-reviewed journals lack supporting clinical evidence for determining accepted uses of drugs.

IV. MEDICATION MANAGEMENT

A. Please refer to the FDA label/package insert for details regarding these topics.

V. APPROVAL AUTHORITY

A. Review – Utilization Management Department

B. Final Approval – Utilization Management Committee

VI. ATTACHMENTS

A. None

VII. REFERENCES

A. Fenaux P, et al. Luspatercept in Patients with Lower-Risk Myelodysplastic Syndromes. N Engl J Med. 2020 Jan 9;382(2):140-151.

B. Reblozyl information. Celgene Summit, NJ 2021.

C. Clinical Pharmacology Elsevier Gold Standard 2021.

D. Micromedex® Healthcare Series: Thomson Micromedex, Greenwood Village, CO 2021.

E. National Comprehensive Cancer Network. Cancer Guidelines and Drugs and Biologics Compendium 2021.

F. AHFS Drug Information. American Society of Health-Systems Pharmacists or Wolters Kluwer Lexi-Drugs. Bethesda, MD 2021.

G. Ellis LM, et al. American Society of Clinical Oncology perspective: Raising the bar for clinical trials by defining clinically meaningful outcomes. J Clin Oncol. 2014 Apr 20;32(12):1277-80.

H. Medicare Benefit Policy Manual Chapter 15 Covered Medical and Other Health Services: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf.