Luspatercept-aamt (Reblozyl®)

IMPORTANT REMINDER

We develop Medical Policies to provide guidance to Members and Providers. This Medical Policy relates only to the services or supplies described in it. The existence of a Medical Policy is not an authorization, certification, explanation of benefits or a contract for the service (or supply) that is referenced in the Medical Policy. For a determination of the benefits that a Member is entitled to receive under his or her health plan, the Member's health plan must be reviewed. If there is a conflict between the medical policy and a health plan or government program (e.g., TennCare), the express terms of the health plan or government program will govern.

POLICY

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.

FDA-Approved Indications

Indicated for:

- Treatment of anemia in adult patients with beta thalassemia who require regular red blood cell (RBC) transfusions
- Treatment of anemia without previous erythropoiesis stimulating agent use (ESA-naïve) in adult patients with very low- to intermediate-risk myelodysplastic syndromes (MDS) who may require regular red blood cell (RBC) transfusions
- 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)

Compendial Use

Myelofibrosis-associated anemia

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 are considered experimental/investigational and not medically necessary.

DOCUMENTATION

Submission of the following information is necessary to initiate the prior authorization review:

Anemia with beta thalassemia
Initial requests:

- Pretreatment or pretransfusion hemoglobin (Hgb) level
- Either of the following:

- Hemoglobin electrophoresis or high-performance liquid chromatography (HPLC) results OR molecular genetic testing results, or
- Chart notes or medical record documentation stating diagnosis of beta thalassemia (β-thalassemia) or hemoglobin E/β-thalassemia was previously confirmed by hemoglobin electrophoresis or HPLC results, OR molecular genetic testing

Anemia of myelodysplastic syndrome or myelodysplastic/myeloproliferative neoplasm
Initial requests:
Pretreatment or pretransfusion hemoglobin (Hgb) level

PRESCRIBER SPECIALTIES

This medication must be prescribed by or in consultation with a hematologist, oncologist, or specialist in the treatment of beta thalassemia.

EXCLUSIONS

Anemia with beta thalassemia
Coverage will not be provided for members who meet any of the following:

- The member has a diagnosis of hemoglobin S/β-thalassemia.
- The member has a diagnosis of alpha-thalassemia.
- The member will use the requested medication concomitantly with mitapivat (Aqvesme).

COVERAGE CRITERIA

Anemia with beta thalassemia

Authorization of 16 weeks may be granted for treatment of anemia with beta thalassemia in members 18 years of age or older when all of the following criteria are met:

- The member has symptomatic anemia evidenced by a pretreatment or pretransfusion Hgb level less than or equal to 11 grams per deciliter (g/dL).
- 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:
  - Hemoglobin electrophoresis or high-performance liquid chromatography (HPLC)
  - Molecular genetic testing
- 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.

Anemia of myelodysplastic syndrome or myelodysplastic/myeloproliferative neoplasm

Authorization of 24 weeks may be granted for treatment of anemia of myelodysplastic syndrome or myelodysplastic/myeloproliferative neoplasm in members 18 years of age or older when all of the following criteria are met:

- The member has either of the following:
  - Very low- to intermediate-risk myelodysplastic syndrome
  - Myelodysplastic/myeloproliferative neoplasm with ring sideroblasts and thrombocytosis (MDS/MPN-RS-T)

- The member has symptomatic anemia evidenced by a pretreatment or pretransfusion Hgb level less than or equal to 11 g/dL.
- The member has been receiving regular red blood cell (RBC) transfusions as defined by greater than or equal to 2 units per 8 weeks.

Myelofibrosis-associated anemia

Authorization of 12 months may be granted for the treatment of myelofibrosis-associated anemia.

CONTINUATION OF THERAPY

Authorization of 12 months may be granted for continued treatment in members requesting authorization for an indication listed in the coverage criteria section when both of the following criteria are met:

- The member has achieved or maintained a reduction in red blood cell transfusion burden.
- The member has not experienced an unacceptable toxicity from Reblozyl.

APPLICABLE TENNESSEE STATE MANDATE REQUIREMENTS

BlueCross BlueShield of Tennessee's Medical Policy complies with Tennessee Code Annotated Section 56-7-2352 regarding coverage of off-label indications of Food and Drug Administration (FDA) approved drugs when the off-label use is recognized in one of the statutorily recognized standard reference compendia or in the published peer-reviewed medical literature.

ADDITIONAL INFORMATION

For appropriate chemotherapy regimens, dosage information, contraindications, precautions, warnings, and monitoring information, please refer to one of the standard reference compendia (e.g., the NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®) published by the National Comprehensive Cancer Network®, Drugdex Evaluations of Micromedex Solutions at Truven Health, or The American Hospital Formulary Service Drug Information).

REFERENCES

1. Reblozyl [package insert]. Summit, NJ: Celgene Corporation, a Bristol-Myers Squibb Company; May 2024.
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(13):1219-31.
3. Benz EJ, Angelucci E. Diagnosis of thalassemia (adults and children). In: UpToDate, Timauer, JS (Ed), UpToDate, Waltham, MA, 2023. URL: www.uptodate.com. Accessed July 15, 2025.
4. National Comprehensive Cancer Network. The NCCN Drugs & Biologics Compendium. http://www.nccn.org. July 15, 2025.
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.
6. Farmakis D, Porter J, Taher A, Cappellini MD, Angastiniotis M, Eleftheriou A. 2021 Thalassaemia International Federation guidelines for the management of transfusion-dependent thalassemia. Hemasphere. 2022;6(8):e732.

EFFECTIVE DATE 6/30/2026

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