Updated: 06/2020
DMMA Approved: 06/2020

Request for Prior Authorization for Reblozyl (luspatercept-aamt)
Website Form – www.highmarkhealthoptions.com
Submit request via: Fax - 1-855-476-4158

All requests for Reblozyl (luspatercept-aamt) require a Prior Authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Reblozyl (luspatercept-aamt) Prior Authorization Criteria:

For all requests for Reblozyl (luspatercept-aamt) all of the following criteria must be met:

- Must be 18 years of age or older
- Must be prescribed by or in consultation with a hematologist
- The requested dose and frequency is in accordance with FDA-approved labeling, nationally recognized compendia, and/or evidence-based practice guidelines

Coverage may be provided with a diagnosis of anemia due to beta thalassemia and the following criteria is met:

- Must have a diagnosis of beta thalassemia or Hemoglobin E/beta-thalassemia
- Must NOT have a diagnosis of Hemoglobin S/beta-thalassemia or alpha-thalassemia (e.g. Hemoglobin H)
- Member requires regular red blood cell (RBC) transfusions (at least 6 RBC units in the past 6 months with no transfusion-free period greater than 35 days)
- **Initial Duration of Approval:** 6 months
- **Reauthorization criteria**
    - Reduction of RBC transfusions compared to baseline
- **Reauthorization Duration of Approval:** 12 months

Coverage may be provided with a diagnosis of anemia in patients with very low, low, or intermediate-risk myelodysplastic syndromes with ring sideroblasts (MDS-RS) or with myelodysplastic/myeloproliferative neoplasm with ring sideroblasts and thrombocytosis (MDS/MPN-RS-T) and the following criteria is met:

- Member requires transfusions of 2 or more red blood cell (RBC) units over 8 weeks
- Must provide documentation showing the member has tried and failed or had an intolerance or contraindication to an erythropoiesis stimulating agent
- **Initial Duration of Approval:** 6 months
- **Reauthorization criteria**
    - Reduction of RBC transfusions compared to baseline
- **Reauthorization Duration of Approval:** 12 months

Coverage may be provided for any non-FDA labeled indication if it is determined that the use is a medically accepted indication supported by nationally recognized pharmacy compendia or peer-reviewed medical literature for treatment of the diagnosis(es) for which it is prescribed. These requests will be reviewed on a case by case basis to determine medical necessity.

Drugs are authorized in generic form unless the branded product is on the preferred drug list or the prescriber has indicated in writing that the branded product is medically necessary. If only the branded product is on the preferred drug list, the generic form will be considered non-preferred and shall not require the prescriber to indicate in writing that the branded product is medically necessary.

Highmark Delaware
HEALTH OPTIONS

Updated: 06/2020
DMMA Approved: 06/2020

REBLOZYL (LUSPATERCEPT-AAMT)
PRIOR AUTHORIZATION FORM

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Highmark Health Options Pharmacy Services. **FAX:** (855) 476-4158
If needed, you may call to speak to a Pharmacy Services Representative.
PHONE: (844) 325-6251 Monday through Friday 8:30am to 5:00pm

PROVIDER INFORMATION

Requesting Provider:	NPI:
Provider Specialty:	Office Contact:
Office Address:	Office Phone:
	Office Fax:

MEMBER INFORMATION

Member Name:	DOB:
Health Options ID:	Member weight: _____pounds or _____kg

REQUESTED DRUG INFORMATION

Medication:	Strength:
Frequency:	Duration:
Is the member currently receiving requested medication? ☐ Yes ☐ No	Date Medication Initiated:

Is this medication being used for a chronic or long-term condition for which the medication may be necessary for the life of the patient? ☐ Yes ☐ No

Billing Information

This medication will be billed: ☐ at a pharmacy **OR**
☐ medically (if medically please provide a JCODE:_____

Place of Service: ☐ Hospital ☐ Provider's office ☐ Member's home ☐ Other

Place of Service Information

Name:	NPI:
Address:	Phone:

MEDICAL HISTORY (Complete for ALL requests)

Diagnosis:

☐ Anemia due to beta thalassemia, ICD-10: _____

- Are regular red blood cell (RBC) transfusions required (at least 6 RBC units in the past 6 months with no transfusion-free period greater than 35 days)? ☐ Yes ☐ No

☐ Anemia in patients with very low, low, or intermediate risk myelodysplastic syndromes with ring sideroblasts (MDS-RS), ICD-10: _____

- Are transfusions of 2 or more red blood cell (RBC) units over 8 weeks required? ☐ Yes ☐ No

☐ Anemia in patients with myelodysplastic/myeloproliferative neoplasm with ring sideroblasts (MDS/MPN-RS-T), ICD-10: _____

- Are transfusions of 2 or more red blood cell (RBC) units over 8 weeks required? ☐ Yes ☐ No

☐ Other: _____ ICD-10: _____

REAUTHORIZATION

Has there been a decrease in transfusions since starting treatment? ☐ Yes ☐ No

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature	Date