Gateway Health℠ It's Wholecare.

Updated: 06/2020
PARP Approved: 07/2020

Prior Authorization Criteria

Reblozyl (luspatercept-aamt)

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

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.

When criteria are not met, the request will be forwarded to a Medical Director for review. The physician reviewer must override criteria when, in their professional judgment, the requested medication is medically necessary.

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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 Gateway Health℠ Pharmacy Services. **FAX:** (888) 245-2049
If needed, you may call to speak to a Pharmacy Services Representative.
PHONE: (800) 392-1147 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:
Gateway 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:

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