NC Medicaid **Medicaid**
Outpatient Pharmacy **Effective Date: xx/xx/xxxx**
Prior Approval Criteria
Reblozyl

DRAFT

Therapeutic Class Code: N1I
Therapeutic Class Description: Antianemia Agents, Erythroid Maturation Agents

Medication
Reblozyl Vial

Eligible Beneficiaries
NC Medicaid (Medicaid) beneficiaries shall be enrolled on the date of service and may have service restrictions due to their eligibility category that would make them ineligible for this service.

EPSDT Special Provision: Exception to Policy Limitations for Beneficiaries under 21 Years of Age

42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid beneficiaries under 21 years of age **if** the service is **medically necessary health care** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination (includes any evaluation by a physician or other licensed clinician). This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his/her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems. Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the beneficiary's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the beneficiary's right to a free choice of providers.
EPSDT does not require the state Medicaid agency to provide any service, product, or procedure

a. that is unsafe, ineffective, or experimental/investigational.
b. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and/or other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure meets all EPSDT criteria, including to
correct or improve or maintain the beneficiary's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT and Prior Approval Requirements
If the service, product, or procedure requires prior approval, the fact that the beneficiary is under 21 years of age does **NOT** eliminate the requirement for prior approval.

IMPORTANT ADDITIONAL INFORMATION about EPSDT and prior approval is found in the NCTracks Provider Claims and Billing Assistance Guide, and on the EPSDT provider page. The Web

addresses are specified below.

***NCTracks Provider Claims and Billing Assistance Guide*:**
https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html
EPSDT provider page: https://medicaid.ncdhhs.gov/medicaid/get-started/find-programs-and-services-right-you/medicaid-benefit-children-and-adolescents

Criteria for initial approval

- Beneficiary must be 18 years of age or older **AND**
- Beneficiary must have one of the following:
  - A documented diagnosis of beta thalassemia (excludes alpha-thalassemia and hemoglobin S/beta-thalassemia variants) as outlined by the following:
    - Beneficiary's diagnosis is confirmed by hemoglobin beta (HBB) sequence gene analysis showing biallelic pathogenic variants; **OR**
    - Beneficiary has severe microcytic/hypochromic anemia, anisopoikilocytosis with nucleated red blood cells on peripheral blood smear, and hemoglobin analysis that reveals decreased amounts or complete absence of hemoglobin A and increased amounts of hemoglobin F; **AND**
    - Beneficiary is RBC transfusion dependent as defined by requiring 6 to 20 RBC units per 24 weeks (for initial approval only; not required on continuation); **OR**
  - A documented diagnosis of anemia without previous erythropoiesis stimulating agent (ESA-naïve) with very low- to intermediate-risk myelodysplastic syndromes (MDS) and that may require regular red blood cell (RBC) transfusions **OR**
  - A documented diagnosis of Anemia failing an erythropoiesis stimulating agent and requiring 2 or more Red Blood Cell (RBC) units over 8 weeks in 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); **AND**

- Beneficiary has not had a deep vein thrombosis or a thrombotic stroke which required medical intervention within 6 months prior to therapy; **AND**
- Beneficiary does NOT have major end organ damage, defined as any of the following:
  - Liver disease with an ALT > 3x the ULN or history of evidence of cirrhosis; **OR**
  - Heart disease, heart failure NYHA classification 3 or higher, or significant arrhythmia requiring treatment, or recent myocardial infarction within 6 months or treatment; **OR**
  - Lung disease, including pulmonary fibrosis or pulmonary hypertension which are clinically significant e.g., grade 3 or higher; **OR**
  - Creatinine clearance < 60ml/min; **AND**
- Beneficiary has a baseline hemoglobin* (HB) <11.5 g/dl (if Hb is ≥ 11.5g/dl, the dose must be delayed until the Hb is ≤11g/dl); **AND**
- Other causes of anemia (e.g. hemolysis, bleeding, recent major surgery, vitamin deficiency) have been ruled out; **AND**
- Female beneficiaries of reproductive potential have a negative pregnancy test prior to start of therapy and will use an effective method of contraception during treatment and for ≥ 3 months after treatment.

Procedures

- Initial approval for 15 weeks (6 initial doses)
- Renewal: 12 months

Criteria for continuation:

- Beneficiary must continue to meet the above initial criteria **AND**
- Beneficiary's Hb***** is <11.5 g/dl (if Hb is ≥ 11.5g/dl, the dose must be delayed until the Hb is ≤ 11 g/dl); **AND**
    - The beneficiary is experiencing disease response as evidenced by a decrease in the number of RBC transfusions; **OR**
    - For new starts, the beneficiary has NOT achieved a reduction in RBC transfusion burden after ≥2 consecutive, initial-doses and requires a dose increase; **OR**
    - Beneficiary has experienced a response followed by a lack/loss of response and requires a dose increase and other causative factors (e.g., a bleeding event) have been ruled out. **AND**

- Beneficiary will not receive doses < 21 days apart; **AND**
- Beneficiary has NOT experienced any treatment-restricting adverse effects (e.g., thromboembolic events, severe hypertension).

*****If an RBC transfusion occurred prior to dosing, the pretransfusion Hb must be considered for dosing purposes. Lab values should be obtained within 7 days of the date of administration.

References:

1 Reblozyl [package insert]. Summit, NJ; Celgene; November 2019.
2. An Efficacy and Safety Study of Luspatercept (ACE-536) Versus Placebo in Adults Who Require Regular Red Blood Cell Transfusions Due to Beta (β) Thalassemia (BELIEVE). NCT02604433. Available at: https://clinicaltrials.gov/ct2/show/NCT02604433?term=NCT02604433&draw=2&rank=1. Accessed February 10, 2020.
3. Viprakasit V, Taher A, Hermine O. Evaluating luspatercept responders in the phase 3, randomized, double-blind, placebo-controlled BELIEVE trial of luspatercept in adult beta-thalassemia patients who require regular red blood cell transfusions. Blood. 2019;134 (Supplement 1): 3545. DOI: 10.1182/blood-2019-122685.
4. FDA approves first therapy to treat patients with rare blood disorder. Available at: https://www.fda.gov/news-events/press-announcements/fda-approves-first-therapy-treat-patients-rare-blood-disorder. Accessed February 11, 2020.
5. National Organization for Rare Disorders. Beta Thalassemia. Available at: https://rarediseases.org/rare-diseases/thalassemia-major/. Accessed February 10, 2020.
6. Thalassemia International Federation. Guidelines for the management of transfusion dependent thalassaemia, 3rd edition - 2014. Available at: https://thalassaemia.org.cy/publications/tif-publications/guidelines-for-the-management-of-transfusion-dependent-thalassaemia-3rd-edition-2014/. Accessed February 10, 2020.

Criteria Change Log

xx/xx/xxxx	Criteria effective date