

<p>SUBJECT: CLINICAL POLICIES – INJECTABLE MEDICATIONS_REBLOZYL (LUSTPATERCEPT-AAMT) FOR ANEMIA IN BETA THALASSEMIA</p> <p>POLICY NUMBER: HS-CP-MA I3u</p> <p>EFFECTIVE DATE: March 25, 2026</p> <p>SERVICE/PRODUCT LINE: MEDICARE – MEDICAL</p>	<p>Product Line (check all that apply):</p> <p><input type="checkbox"/> All</p> <p><input type="checkbox"/> Group HMO</p> <p><input type="checkbox"/> Individual HMO</p> <p><input type="checkbox"/> PPO</p> <p><input type="checkbox"/> POS</p> <p><input checked="" type="checkbox"/> Medicare</p> <p><input type="checkbox"/> N/A</p>
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These guidelines are used in conjunction with the independent judgment of a qualified licensed physician and do not constitute the practice of medicine or medical advice. This Clinical Policy is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment by providing the most appropriate care and are solely responsible for the medical advice and treatment of members. This Clinical Policy is not intended to recommend treatment for members. Members should consult with their treating provider in connection with diagnosis and treatment decisions.

When coverage criteria are not fully established by Medicare including but not limited to National Coverage Decisions (NCD), Local Coverage Decisions (LCD), Medicare Manuals and National Coverage Articles, Sharp Health Plan develops Clinical Policies that serve as recommendations for medical necessity decisions. Sharp Health Plan utilizes evidence-based guidelines from nationally recognized professional organizations, peer reviewed medical and scientific literature and evidence-based consensus statements, which are all based on generally accepted standards of care.

I. BENEFIT STATEMENT: Any service reviewed and approved by this Sharp Health Plan Clinical Policy must be a covered benefit according to the member’s evidence of coverage (EOC). Since benefit plans vary in coverage and some plans may not provide coverage for certain services discussed in this clinical policy, decisions are subject to all terms and conditions of the applicable benefit plan. Benefit determinations should be based in all cases on the member’s contract benefits in effect at the time of service.

All reviewers must first identify member eligibility, and all decisions of this clinical policy are subject to current state and/or federal law. This Clinical policy does not constitute plan authorization, nor is it an explanation of benefits. In the event of a conflict, a member’s benefit plan, EOC, always supersedes the information in the Clinical Policies.

II. REGULATORY: N/A

III. DESCRIPTION

- A. Before using this policy, please check the member specific benefit plan document and any federal mandates, if applicable.
- B. This policy defines the Sharp Health Plan (Plan) coverage for Reblozyl (luspatercept-aamt) when administered according to U.S. Food and Drug Administration (FDA) labeled indications.
- C. This policy is to be used when there are no CMS criteria (NCD, LCF, NCA, Medicare Manual) for the drug in question.

D. Reblozyl is, an erythroid maturation agent, approved by the Federal Drug Administration (FDA) for:

Indication	Dosing
Anemia in transfusion dependent beta thalassemia	1 mg/kg injected subcutaneously by a healthcare provider every 3 weeks. Increase or decrease dosing based on Predose hemoglobin levels and change in RBC. transfusion burden (Max Dose: 1.25 mg/kg).

IV. DEFINITIONS

- A. A Qualified Individual is a Sharp Health Plan (Plan) member.
- B. Experimental and Investigational drugs and devices:
 - 1. Considered experimental if the FDA has not issued a specific indication or NDC number for the specific drug or device AND they are currently under investigation in a registered Clinical Trial.
 - 2. The Off-Label Use of an FDA approved prescription drug or device is not considered an experimental/investigational service if this off-label use is not currently being investigated in a registered Clinical Trial.
- C. Biosimilars: A biosimilar is a biologic that is highly similar to, and has no clinically meaningful differences from, another biologic that is already approved by the FDA (known as the original biologic or reference product). Biosimilars are made with the same types of natural sources as the original medication they were compared to; they are given the same way, have the same strength and dosage, and have the same potential side effects. A biosimilar provides the same treatment benefits as the original biologic.
- D. Injection: The introduction of a medicinal substance into the body; either subcutaneous, intramuscular, intravenous, intra-arterial or into other canals or cavities of the body. For purposes of this medical policy, a medication is provided either by a member (self-injectable) or by a medical provider. It is a “shot” or a dosage of medication given by way of a syringe and needle rather than over a period of time, though not to be given as part of a procedure.
- E. Infusion: The slow diagnostic, prophylactic, or therapeutic introduction of fluid or medicinal substance into a vein or tissue given over a period of time.

V. MEDICAL NECESSITY

- A. To be eligible for coverage under this policy, the member must be a Qualified Individual with active Plan membership.
- B. Additionally, the provision of physician samples does not guarantee coverage.
- C. Medications must be prescribed from a contracted Plan provider.
- D. Reblozyl (luspatercept-aamt) for Beta thalassemia:
 - 1. Initial Criteria (must meet ALL):
 - a) The medication is prescribed by, or in consultation with, a hematologist.
 - b) The member is 18 years and older with a diagnosis of beta thalassemia.
 - c) The member’s condition requires regular packed red blood cell (pRBC) transfusions, defined as:

- (1) Total volume of transfusions greater than or equal to 6 pRBC units within the last 6 months
 - (2) No transfusion-free period lasting greater than 35 days in the last 6 months
 - d) The members' baseline hemoglobin level is less than or equal to 11.5 g/dL.
 - e) The members' baseline transfusion burden within the last 6 months is documented.
 - f) Dosing for beta thalassemia is in accordance with the Food and Drug Administration
 - g) Initial authorization will be for no more than 8 doses (6 months).
2. Reauthorization criteria:
- a) Member has documented benefit from Reblozyl as evidenced by one of the following:
 - (1) The member has experienced a decreased in transfusion burden from baseline.
 - (2) The member has achieved or maintained transfusion independence.
 - b) The members' baseline hemoglobin level is less than or equal to 11 g/dL.
 - c) Dosing is accordance with the Food and Drug Administration approved labeling.
 - d) Reauthorization will be for no more than 12 months.

VI. NOT MEDICALLY NECESSARY

- A. The Plan is not required to cover services or benefits that are not otherwise covered under the terms and conditions of the Plan contract.
- B. Reblozyl is considered not medically necessary for beta thalassemia when any of the above criteria have not been met.

VII. PROCEDURE/ATTACHMENTS

- A. All requests for medical injectable coverage will be reviewed by the delegated Plan Medical Group (PMG) or by the Plan, according to its regular and appropriate utilization management process, administered consistent with the Plan benefit.
- B. All reviewers must first identify enrollee eligibility, any federal or state regulatory requirements and the plan benefit coverage prior to use of this guideline. This Policy provides assistance in determining coverage under the member's benefit plan.
- C. The terms of a member's benefit plan summary defined in the evidence of coverage document may differ from the standard benefit plans upon which this guideline is based. In the event of a conflict, the member's specific benefit document supersedes these guidelines.

VIII. CODES: N/A**IX. REFERENCES:**

- A. Reblozyl [package insert]. Summit, NJ: Celgene corporation.; May 2024.
- B. Thalassaemia International Federation. Guidelines for the management of transfusion dependent thalassaemia (TDT); 2021. Available from: Guidelines for the Management of Transfusion Dependent Thalassaemia (4th edition – Version 2.0) – TIF.

- C. UpToDate inc. Diagnosis of thalassemia (adults and children). UpToDate [database online]. Last updated April 2022.
- D. UpToDate inc. Management of thalassemia. UpToDate [database online]. Last updated August 2022.
- E. Cappellini MD, Viprakasit V, Taher AT, et al. A Phase 3 Trial of Luspatercept in Patients with Transfusion-Dependent β -Thalassemia. New England Journal of Medicine. 2020;382(13):1219-1231. doi:10.1056/nejmoa1910182
- F. Greenberg, Tuechler, Schanz et al, Revised International Prognostic Scoring System (IPSS-R) for

X. REVISION HISTORY:

Date	Modification (Original, Reviewed or Revised)
03/25/2026	No criteria changes. Removed references related to MDS and MDS/MPN as no oncology criteria included in this policy.
03/26/2025	Original

Approved by: (Signature of VP /CMO) 	Approval date: 3/25/26
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