PRIOR AUTHORIZATION POLICY

POLICY: Hematology – Rytelo Prior Authorization Policy
- Rytelo® (imetelstat intravenous infusion – Geron)

REVIEW DATE: 06/12/2024

OVERVIEW

Rytelo, an oligonucleotide telomerase inhibitor, is indicated for the treatment of **transfusion-dependent anemia** in adults with **low- to intermediate-1 risk myelodysplastic syndrome (MDS)** requiring ≥ 4 red blood cell units over 8 weeks who have not responded to, have lost response to, or are ineligible for erythropoiesis-stimulating agents (ESAs).[1]

Rytelo was not studied in patients with deletion 5q [del(5q)] cytogenetic abnormality.[1] Discontinue if a patient does not experience a decrease in red blood cell transfusion burden after 24 weeks of treatment (administration of 6 doses) or if unacceptable toxicity occurs at any time.

Guidelines

The National Comprehensive Cancer Network guidelines for MDS (version 3.2024 – July 25, 2024) are extensive.[2] The following NCCN recommendations for Rytelo for the treatment of MDS in lower-risk disease associated with symptomatic anemia are for patients without del(5q) with or without other cytogenic abnormalities. A patient is considered ring sideroblast positive (RS+) if ring sideroblasts are ≥ 15% (or ring sideroblasts ≥ 5% with an SF3B1 mutation). A patient is considered ring sideroblast negative (RS-) if ring sideroblasts <15% (or ring sideroblasts <5% with an SF3B1 mutation). The guidelines categorize patients without the del(5q) abnormality on the basis of ring sideroblasts and serum erythropoietin level without specifying red blood cell transfusion burden.

- For patients who are RS- and have a serum erythropoietin ≤ 500 mU/mL, Rytelo is recommended following no response to ESAs (specifically epoetin alfa products or Aranesp) or Reblozyl® (luspatercept-aamt subcutaneous injection) (**category 1**). For patients who are RS- and have a serum erythropoietin > 500 mU/mL, Rytelo is listed as an "Other Recommended Regimen" to the preferred (azacitidine injection) [category 2A] for patients with a poor probability to respond to immunosuppressive therapy and/or following no response or an intolerance to immunosuppressive therapy.
- For patients who are RS+, Rytelo is recommended following no response to Reblozyl if serum erythropoietin ≤ 500 mU/mL (**category 1**) and if serum erythropoietin > 500 mU/mL (category 2A). For patients who are RS+ and have serum erythropoietin > 500 mU/mL, Rytelo is recommended as initial treatment as well as recommended following no response to Reblozyl (both category 2A).

POLICY STATEMENT

Prior Authorization is recommended for prescription benefit coverage of Rytelo. All approvals are provided for the duration noted below. In cases where the approval is authorized in months, 1 month is equal to 30 days. Because of the specialized skills required for evaluation and diagnosis of patients treated with Rytelo as well as the monitoring required for adverse events and long-term efficacy, approval requires Rytelo to be prescribed by or in consultation with a physician who specializes in the condition being treated.

Automation: None.

RECOMMENDED AUTHORIZATION CRITERIA

Coverage of Rytelo is recommended in those who meet the following criteria:

FDA-Approved Indication

1. **Myelodysplastic Syndrome.** Approve for the duration noted if the patient meets ONE of the following (A or B):
   - **A)** Initial Therapy. Approve for 6 months if the patient meets ALL of the following (i, ii, iii, iv, v, vi, and vii):
     - **i.** Patient is ≥ 18 years of age; AND
     - **ii.** According to the prescriber, patient has low- to intermediate-1 risk myelodysplastic syndrome (MDS); AND
       Note: MDS risk category is determined using the International Prognostic Scoring System (IPSS).
     - **iii.** Patient has transfusion-dependent anemia, defined as requiring transfusion of ≥ 4 red blood cell units over an 8-week period; AND
     - **iv.** According to the prescriber, patient has not responded, lost response to, or is ineligible for erythropoiesis-stimulating agents; AND
       Note: Examples of erythropoiesis-stimulating agents include an epoetin alfa product (e.g., Epogen, Procrit, or Retacrit), a darbepoetin alfa product (e.g., Aranesp), or a methoxy polyethylene glycol-epoetin beta product (e.g., Mircera).
     - **v.** Patient does NOT have deletion 5q [del(5q)] cytogenic abnormality; AND
     - **vi.** Rytelo will NOT be used in combination with an erythropoiesis stimulating agent; AND
     - **vii.** The medication is being prescribed by or in consultation with an oncologist or hematologist; OR
   - **B)** Patient is Currently Receiving Rytelo. Approve for 1 year if, according to the prescriber, the patient has experienced a clinically meaningful decrease in transfusion burden.
     Note: For a patient who has not received 6 months (24 weeks) of therapy or who is restarting therapy, refer to Initial Therapy criteria above.

CONDITIONS NOT RECOMMENDED FOR APPROVAL

Coverage of Rytelo is not recommended in the following situations:

1. Coverage is not recommended for circumstances not listed in the Recommended Authorization Criteria. Criteria will be updated as new published data are available.

REFERENCES

1. Rytelo® intravenous infusion [prescribing information]. Foster City, CA: Geron; June 2024.
2. The NCCN Myelodysplastic Syndromes Clinical Practice Guidelines in Oncology (version 3.2024 – July 25, 2024). © 2024 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed on July 30, 2024.