



Reblozyl (luspatercept-aamf)
Effective 06/01/2020

Plan	<input checked="" type="checkbox"/> MassHealth <input type="checkbox"/> Commercial/Exchange	Program Type	<input checked="" type="checkbox"/> Prior Authorization
Benefit	<input type="checkbox"/> Pharmacy Benefit <input checked="" type="checkbox"/> Medical Benefit (NLX)		<input type="checkbox"/> Quantity Limit <input type="checkbox"/> Step Therapy
Specialty Limitations	N/A		
Contact Information	Specialty Medications		
	All Plans	Phone: 866-814-5506	Fax: 866-249-6155
	Non-Specialty Medications		
	MassHealth	Phone: 877-433-7643	Fax: 866-255-7569
	Commercial	Phone: 800-294-5979	Fax: 888-836-0730
	Exchange	Phone: 855-582-2022	Fax: 855-245-2134
	Medical Specialty Medications (NLX)		
	All Plans	Phone: 844-345-2803	Fax: 844-851-0882
Exceptions	N/A		

Overview

Luspatercept is a recombinant fusion protein that contains a modified form of the extracellular domain of human activin receptor type IIb and links to the human IgG1 Fc domain. It binds several endogenous transforming growth factor-beta (TGF-β) superfamily ligands, which results in reduced Smad2/3 signaling. Inhibition of TGF-β superfamily results in increased differentiation and proliferation of erythroid precursors and improves hematology parameters associated with ineffective erythropoiesis. Luspatercept is indicated for treatment of anemia in adults with beta thalassemia who require regular red blood cell transfusions.

Coverage Guidelines

Authorization may be granted for members new to the plan who are currently receiving treatment with Reblozyl, excluding when the product is obtained as samples or via manufacturer’s patient assistance programs

OR

Authorization may be granted if the member meets all following criteria and documentation has been submitted:

1. The member has medical records and genetic testing supporting diagnosis of transfusion-dependent beta thalassemia
2. The member is ≥ 18 years of age
3. The provider is a hematologist or medication is being prescribed in consultation with a hematologist.

Continuation of Therapy

Reauthorization may be granted for members who have met the initial criteria and the physician has submitted clinical documentation of clinical response (e.g., decrease in transfusion requirements).



Limitations

- 1. Initial approvals will be granted for 6 months
- 2. Reauthorization may be granted for 12 months

Dosing

Reblozyl Subcutaneous solution 25mg & 75mg	Initial Dose: 1 mg/kg once every 3 weeks May increase dose to 1.25 mg/kg once every 3 weeks Maximum dose: 1.25 mg/kg
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References

- 1. Reblozyl (luspatercept) [prescribing information]. Summit, NJ: Celgene Corporation; November 2019.

Review History

03/18/2020 – Created and Reviewed P&T Mtg (effective 6/1/20)

11/16/2022 – Reviewed for Nov P&T. Separated out MH vs Comm/Exch. No clinical changes

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