# Clinical Policy: Imetelstat (Rytelo)

Reference Number: LA.PHAR.690
Effective Date:
Last Review Date: 08.23.24
Line of Business: Medicaid

Coding Implications
Revision Log

**See Important Reminder at the end of this policy for important regulatory and legal information.**

****Please note: This policy is for medical benefit****

## Description

Imetelstat (Rytelo™) is an oligonucleotide telomerase inhibitor.

## FDA Approved Indication(s)

Rytelo is indicated for the treatment of adult patients with low- to intermediate-1 risk myelodysplastic syndromes (MDS) with transfusion-dependent anemia requiring 4 or more red blood cell (RBC) units over 8 weeks who have not responded to or have lost response to or are ineligible for erythropoiesis-stimulating agents (ESA).

## Policy/Criteria

*Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.*

It is the policy of Louisiana Healthcare Connections that Rytelo **medically necessary** when the following criteria are met:

**I. Initial Approval Criteria**

**A. Myelodysplastic Syndromes** (must meet all)**:**

1. Diagnosis of MDS with transfusion-dependent anemia;
2. Prescribed by or in consultation with a hematologist or oncologist;
3. Age ≥ 18 years;
4. Member has low risk or intermediate-1 risk MDS disease as classified by IPSS (*see Appendix D*);
5. Documentation of at least 4 RBC units transfused over 8 weeks;
6. Member does not have del(5q) cytogenetic abnormality;
7. Member meets one of the following (a or b):
   a. Inadequate response to or ineligible for ESA therapy (e.g., epoetin alfa, darbepoetin, *see Appendix B*);
   b. One of the following (i or ii):
      i. Failure of Retacrit™, unless contraindicated or clinically significant adverse effects are experienced;
      **Prior authorization may be required for Retacrit*
      ii. If Retacrit is unavailable due to shortage, member must use Epogen®, unless contraindicated or clinically significant adverse effects are experienced;
      **Prior authorization may be required for Epogen*

8. Rytelo is not prescribed concurrently with Reblozyl®;

9. Request meets one of the following (a or b):*
   a. Dose does not exceed 7.1 mg/kg every 4 weeks;
   b. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

**Prescribed regimen must be FDA-approved or recommended by NCCN*

**Approval duration: 6 months**

**B. Other diagnoses/indications** (must meet all)**:**

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, referLA.PMN.255 for Medicaid
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policyLA.PMN.53 for Medicaid.

## II. Continued Therapy

**A. Myelodysplastic Syndromes** (must meet all)**:**

1. Currently receiving medication via Louisiana Healthcare Connections benefit or member has previously met initial approval criteria;
2. Member is responding positively to therapy as evidence by decrease of RBC transfusions requirement;
3. Rytelo is not prescribed concurrently with Reblozyl;
4. If request is for a dose increase, request meets one of the following (a or b):*
   a. Dose does not exceed 7.1 mg/kg every 4 weeks;
   b. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

**Prescribed regimen must be FDA-approved or recommended by NCCN*

**Approval duration: 6 months**

**B. Other diagnoses/indications** (must meet 1 or 2)**:**

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer toLA.PMN.255 for Medicaid
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policyLA.PMN.53 for Medicaid.

## III. Diagnoses/Indications for which coverage is NOT authorized:

**A.** Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies – LA.PMN.53 for Medicaid or evidence of coverage documents.

## IV. Appendices/General Information

*Appendix A: Abbreviation/Acronym Key*

ESA: erythropoiesis-stimulating agent
FDA: Food and Drug Administration
IPSS: International Prognostic Scoring System
MDS: myelodysplastic syndrome
RBC: red blood cell

*Appendix B: Therapeutic Alternatives*
*This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent and may require prior authorization.*

| Drug Name | Dosing Regimen | Dose Limit/ Maximum Dose |
|---|---|---|
| Procrit®, Epogen®, Retacrit® (epoetin alfa)* | 40,000 to 60,000 units SC 1 to 2 times per week every week | Target hemoglobin up to 12 g/dL |
| Aranesp® (darbepoetin alfa)* | 150 to 300 mcg SC every other week | Target hemoglobin up to 12 g/dL |

*Therapeutic alternatives are listed as Brand name® (generic) when the drug is available by brand name only and generic (Brand name®) when the drug is available by both brand and generic.*
**Off-label*

*Appendix C: Contraindications/Boxed Warnings*
None reported

*Appendix D: MDS Risk Classification*
- International Prognostic Scoring System (IPSS) classification:

| Risk Category | Risk Score |
|---|---|
| Low | 0 |
| Intermediate-1 | 0.5 – 1 |
| Intermediate-2 | 1.5 – 2 |
| High | 2.5 – 3.5 |

## V. Dosage and Administration

| Indication | Dosing Regimen | Maximum Dose |
|---|---|---|
| MDS | 7.1 mg/kg intravenous infusion over 2 hours every 4 weeks | 7.1 mg/kg/4 weeks |

## VI. Product Availability
Single-dose vials: 47 mg, 188 mg

## VII. References

1. Rytelo Prescribing Information. Foster City, CA: Geron Corporation.; June 2024. Available at: https://www.accessdata.fda.gov/drugsatfda_docs/label/2024/217779s000lbl.pdf. Accessed June 17, 2024.
2. Bohlius J, Bohlke K, Castelli R, et al. American Society of Hematology/American Society of Clinical Oncology clinical practice guideline update: Management of Cancer-Associated Anemia with Erythropoiesis-Stimulating Agents. 2019 May 20; J Clin Oncol 37:1336-1351. Available at: https://ascopubs.org/doi/pdf/10.1200/JCO.18.02142.

3. Clinical Pharmacology [database online]. Elsevier, Inc.; 2024. Available at: https://www.clinicalkey.com/pharmacology/. Accessed June 18, 2024.
4. National Comprehensive Cancer Network. Myelodysplastic Syndromes Version 2.2024. Available at: https://www.nccn.org/professionals/physician_gls/pdf/mds.pdf. Accessed June 20, 2024.
5. Platzbecker U, Santini V, Fenaux P, et al. Imetelstat in patients with lower-risk myelodysplastic syndromes who have relapsed or are refractory to erythropoiesis-stimulating agents (IMerge): a multinational, randomized, double-blind, placebo-controlled, phase 3 trial. Lancet. 2024 Jan 20;403(10423):249-260. doi: 10.1016/S0140-6736(23)01724-5. Epub 2023 Dec 1. Erratum in: Lancet. 2024 Jan 20;403(10423):248. doi: 10.1016/S0140-6736(24)00057-6. PMID: 38048786.

**Coding Implications**
Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

| HCPCS Codes | Description |
|---|---|
| C9399 | Unclassified drugs or biologicals |
| J9999 | Not otherwise classified, antineoplastic drugs |

| Reviews, Revisions, and Approvals | Date | LDH Approval Date |
|---|---|---|
| Converted to local policy. | 08.23.24 | |

**Important Reminder**
This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. LHCC makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved.
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