

<u>Field Name</u>	<u>Field Description</u>
<u>Prior Authorization Group Description</u>	<u>Rytelo</u>
<u>Drugs</u>	<u>Rytelo (imetelstat)</u>
<u>Covered Uses</u>	<u>Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.</u>
<u>Exclusion Criteria</u>	<u>N/A</u>
<u>Required Medical Information</u>	<u>See “Other Criteria”</u>
<u>Age Restrictions</u>	<u>Member must be 18 years of age and older</u>
<u>Prescriber Restrictions</u>	<u>Prescriber must be a hematologist or oncologist</u>
<u>Coverage Duration</u>	<u>If all of the criteria are met, the initial request will be approved for 6 months. For continuation of therapy, the request will be approved for 6 months.</u>
<u>Other Criteria</u>	<p><u>**Drug is being requested through the member’s medical benefit**</u></p> <p><u>Initial Authorization:</u></p> <ul style="list-style-type: none"> <li>• <u>Diagnosis of myelodysplastic syndromes (MDS) with transfusion-dependent anemia</u></li> <li>• <u>Myelodysplastic Syndrome Revised International Prognostic Scoring System (IPSS-R) categorization as low or intermediate-1 risk of progression</u></li> <li>• <u>Member has transfusion burden of 4 or more red blood cell (RBC) units within an 8-week period over the last 4 months</u></li> <li>• <u>Prescriber attestation that complete blood cell count (CBC) will be obtained prior to initiation, weekly for first two cycles, and prior to each cycle thereafter</u></li> <li>• <u>Member’s weight has been provided with request</u></li> <li>• <u>Medication is prescribed at an FDA approved dose</u></li> </ul> <p><u>Re-Authorization:</u></p> <ul style="list-style-type: none"> <li>• <u>Documentation or provider attestation of reduction in RBC transfusion burden as compared with baseline</u></li> <li>• <u>Provider attestation that patient is tolerating the medication and is not experiencing any serious adverse reactions</u></li> <li>• <u>Member’s weight has been provided with request</u></li> <li>• <u>Medication is prescribed at an FDA approved dose</u></li> </ul>
<u>Revision/ Review Date: 11/2024</u>	

	<b><u>If all of the above criteria are not met, the request is referred to a Medical Director/Clinical Reviewer for medical necessity review.</u></b>
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