Rytelo™ (imetelstat)
(Intravenous)

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I. Length of Authorization [1]

- Initial: Prior authorization validity will be provided initially for 6 months.
- Renewal: Prior authorization validity may be renewed every 6 months thereafter.

II. Dosing Limits

Max Units (per dose and over time) [HCPCS Unit]:

- 940 billable units every 4 weeks

III. Initial Approval Criteria [1]

Prior authorization validity is provided in the following conditions:

- Patient is at least 18 years of age; **AND**

Myelodysplastic Syndrome (MDS) † ‡ Φ[1-4]

- Patient has symptomatic anemia; **AND**
    - Patient has lower risk disease (defined as International Prognostic Scoring System (IPSS) low- to intermediate-1) **†**; **AND**
        - Patient is relapsed or refractory to ESA therapy or is ESA ineligible (i.e., Erythropoietin (EPO)>500 mU/mL); **AND**
        - Patient is red blood cell (RBC) transfusion dependent, defined as requiring at least 4 RBC units transfused over an 8-week period**; OR**
    - Patient has lower risk disease (defined as IPSS-R [Very Low, Low Intermediate]) **‡**; **AND**
        - Patient has del(5q) mutation (except those involving chromosome 7); **AND**
            - Used for one of the following:
                - Patient has no response to or relapse after lenalidomide; **OR**
                - Patient has no response to or relapse after erythropoiesis-stimulating agent (ESA) and patient serum erythropoietin is ≤ 500 mU/mL; **AND**
            - Patient has no response to, intolerance, relapse or a poor probability of response to immunosuppressive therapy (IST); **OR**
        - Patient does not have del(5q) mutation; **AND**

- Patient has ring sideroblasts < 15% (or <5% with an SF3B1 mutation); **AND**
  - Patient has a serum erythropoietin (EPO) ≤ 500 mU/mL; **AND**
    - Used following no response to or relapse after either an ESA (despite adequate iron stores) or luspatercept-aamt; **OR**
    - Used following no response to or relapse after either an ESA alone or luspatercept, followed by no response/relapse after either an ESA (with or without lenalidomide or a granulocyte-colony stimulating factor [G-CSF]), or to luspatercept alone (if not previously used); **OR**
  - Patient has a serum EPO > 500 mU/mL; **AND**
    - Patient has no response, intolerance, relapse or a poor probability of response to IST; **OR**
- Patient has ring sideroblasts ≥15% (or ring sideroblasts ≥5% with an SF3B1 mutation); **AND**
  - Used following no response to or relapse after luspatercept; **OR**
  - Used as initial treatment (ineligible for ESAs); **AND**
    - Patient has a serum EPO > 500 mU/mL

† FDA Approved Indications; ‡ Compendia Recommended Indication(s); Φ Orphan Drug

IV. Renewal Criteria [1-5]

Prior authorization validity can be renewed based upon the following criteria:

- Patient continues to meet the indication-specific relevant criteria such as concomitant therapy requirements (not including prerequisite therapy), performance status, etc. identified in section III; **AND**
- Absence of unacceptable toxicity from the drug. Examples of unacceptable toxicity include: severe thrombocytopenia, neutropenia, and severe infusion-related reactions, etc.; **AND**

Myelodysplastic Syndromes (MDS)

- Patient has disease response as evidenced by at least one of the following: increase in platelets, increase in hemoglobin, or increase in WBC/ANC over pretreatment values, or a decrease in RBC transfusions.

V. Dosage/Administration [1]

Indication	Dose
Myelodysplastic Syndromes (MDS)	The recommended dosage of Rytelo is 7.1 mg/kg administered as an intravenous infusion over 2 hours every 4 weeks.

- *Administer pre-treatment medications at least 30 minutes prior to dosing to prevent or reduce potential infusion-related reactions and monitor patients for adverse reactions for at least one hour after the infusion has been completed.*
- *Refer to prescribing information for recommended dosage modifications for adverse reactions.*

VI. Billing Code/Availability Information

HCPCS Code:

- J0870 – Injection, imetelstat, 1 mg; 1 billable unit = 1 mg

NDC(s):

- Rytelo 47 mg powder in a single-dose vial: 82959-0112-xx
- Rytelo 188 mg powder in a single-dose vial: 82959-0111-xx

VII. References

1. Rytelo [package insert]. Foster City, CA; Geron, Inc: June 2024. Accessed April 2025.
2. Referenced with permission from the NCCN Drugs & Biologics Compendium (NCCN Compendium®) imetelstat. National Comprehensive Cancer Network, 2025. The NCCN Compendium® is a derivative work of the NCCN Guidelines®. NATIONAL COMPREHENSIVE CANCER NETWORK®, NCCN®, and NCCN GUIDELINES® are trademarks owned by the National Comprehensive Cancer Network, Inc. To view the most recent and complete version of the Compendium, go online to NCCN.org. Accessed April 2025.
3. Referenced with permission from the NCCN Drugs & Biologics Compendium (NCCN Compendium®) Myelodysplastic Syndromes. Version 2.2025. National Comprehensive Cancer Network, 2025. The NCCN Compendium® is a derivative work of the NCCN Guidelines®. NATIONAL COMPREHENSIVE CANCER NETWORK®, NCCN®, and NCCN GUIDELINES® are trademarks owned by the National Comprehensive Cancer Network, Inc. To view the most recent and complete version of the Compendium, go online to NCCN.org. Accessed April 2025.
4. Zeidan AM, Platzbecker U, Santini V, et al. IMerge: Results from a phase 3, randomized, double-blind, placebo-controlled study of imetelstat in patients (pts) with heavily transfusion dependent (TD) non-del(5q) lower-risk myelodysplastic syndromes (LR-MDS) relapsed/refractory (R/R) to erythropoiesis stimulating agents (ESA). Meeting Abstract: 2023 ASCO Annual Meeting I. Journal of Clinical Oncology Volume 41, Number 16_suppl June 2023. DOI:10.1200/JCO.2023.41.16_suppl.7004
5. Amer M. Zeidan, Uwe Platzbecker, Jan Philipp Bewersdorf, et al. Consensus proposal for revised International Working Group 2023 response criteria for higher-risk myelodysplastic syndromes. *Blood* 2023; 141 (17): 2047–2061. doi: https://doi.org/10.1182/blood.2022018604

Appendix A – Non-Quantitative Treatment Limitations (NQTL) Factor Checklist

Non-quantitative treatment limitations (NQTLs) refer to the methods, guidelines, standards of evidence, or other conditions that can restrict how long or to what extent benefits are provided under a health plan.

These may include things like utilization review or prior authorization. The utilization management NQTL applies comparably, and not more stringently, to mental health/substance use disorder (MH/SUD) Medical Benefit Prescription Drugs and medical/surgical (M/S) Medical Benefit Prescription Drugs. The table below lists the factors that were considered in designing and applying prior authorization to this drug/drug group, and a summary of the conclusions that Prime's assessment led to for each.

Factor	Conclusion
Indication	Yes: Consider for PA
Safety and efficacy	No: PA not a priority
Potential for misuse/abuse	No: PA not a priority
Cost of drug	Yes: Consider for PA

Appendix 1 – Covered Diagnosis Codes

ICD-10	ICD-10 Description
C93.10	Chronic myelomonocytic leukemia not having achieved remission
D46.0	Refractory anemia without ring sideroblasts, so stated
D46.1	Refractory anemia with ring sideroblasts
D46.20	Refractory anemia with excess of blasts, unspecified
D46.21	Refractory anemia with excess of blasts 1
D46.4	Refractory anemia, unspecified
D46.9	Myelodysplastic syndrome, unspecified
D46.A	Refractory cytopenia with multilineage dysplasia
D46.B	Refractory cytopenia with multilineage dysplasia and ring sideroblasts
D46.C	Myelodysplastic syndrome with isolated del(5q) chromosomal abnormality
D46.Z	Other myelodysplastic syndromes

Appendix 2 – Centers for Medicare and Medicaid Services (CMS)

The preceding information is intended for non-Medicare coverage determinations. Medicare coverage for outpatient (Part B) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals. In addition, National Coverage Determinations (NCDs) and/or Local Coverage Determinations (LCDs) may exist and compliance with these policies is required where applicable. Local Coverage Articles (LCAs) may also exist for claims payment purposes or to clarify benefit eligibility under Part B for drugs which may be self-administered. The following link may be used to search for NCD, LCD, or LCA documents: https://www.cms.gov/medicare-coverage-database/search.aspx. Additional indications, including any preceding information, may be applied at the discretion of the health plan.

Medicare Part B Covered Diagnosis Codes (applicable to existing NCD/LCD/LCA): N/A

Medicare Part B Administrative Contractor (MAC) Jurisdictions		
Jurisdiction	**Applicable State/US Territory**	**Contractor**
E (1)	CA, HI, NV, AS, GU, CNMI	Noridian Healthcare Solutions, LLC
F (2 & 3)	AK, WA, OR, ID, ND, SD, MT, WY, UT, AZ	Noridian Healthcare Solutions, LLC
5	KS, NE, IA, MO	Wisconsin Physicians Service Insurance Corp (WPS)
6	MN, WI, IL	National Government Services, Inc. (NGS)
H (4 & 7)	LA, AR, MS, TX, OK, CO, NM	Novitas Solutions, Inc.
8	MI, IN	Wisconsin Physicians Service Insurance Corp (WPS)
N (9)	FL, PR, VI	First Coast Service Options, Inc.
J (10)	TN, GA, AL	Palmetto GBA
M (11)	NC, SC, WV, VA (excluding below)	Palmetto GBA
L (12)	DE, MD, PA, NJ, DC (includes Arlington & Fairfax counties and the city of Alexandria in VA)	Novitas Solutions, Inc.
K (13 & 14)	NY, CT, MA, RI, VT, ME, NH	National Government Services, Inc. (NGS)
15	KY, OH	CGS Administrators, LLC