Clinical Policy: Imetelstat (Rytelo)

Reference Number: PA.CP.PHAR.690
Effective Date: 08/2024
Last Review Date: 07/2025

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 PA Health & Wellness® that Rytelo is **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. Failure of Retacrit™ or Epogen®, unless contraindicated or clinically significant adverse effects are experienced;
      **Prior authorization may be required for Retacrit and 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*).

Approval duration: 6 months

B. Other diagnoses/indications

1. Refer to the off-label use policy if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): PA.CP.PMN.53

II. Continued Therapy

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

1. Currently receiving medication via PA Health & Wellness benefit and documentation supports positive response to therapy or the Continuity of Care policy (PA.PHARM.01) applies;
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*).

Approval duration: 6 months

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

1. Currently receiving medication via PA Health & Wellness benefit and documentation supports positive response to therapy or the Continuity of Care policy (PA.PHARM.01) applies.
   Approval duration: Duration of request or 12 months (whichever is less); or
2. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): PA.CP.PMN.53

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 – PA.CP.PMN.53

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

VI. 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 April 17, 2025.
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]. Philadelphia, PA: Elsevier.; 2025. Available at: https://www.clinicalkey.com/pharmacology/. Accessed June 2, 2025.
4. National Comprehensive Cancer Network. Myelodysplastic Syndromes Version 2.2025. Available at: https://www.nccn.org/professionals/physician_gls/pdf/mds.pdf. Accessed June 2, 2025.
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
J0870	Injection, imetelstat, 1 mg

Reviews, Revisions, and Approvals	Date
Policy created	07/2024
3Q 2025 annual review: no significant changes; HCPCS code added [J0870] and removed codes [C9399, J9999]; references reviewed and updated.	07/2025