Drug Coverage Policy

Effective Date.....4/1/2026
Coverage Policy Number.....IP0693
Policy Title.....Rytelo

Hematology – Rytelo

- Rytelo® (imetelstat intravenous infusion – Geron)

INSTRUCTIONS FOR USE
The following Coverage Policy applies to health benefit plans administered by Cigna Companies. Certain Cigna Companies and/or lines of business only provide utilization review services to clients and do not make coverage determinations. References to standard benefit plan language and coverage determinations do not apply to those clients. Coverage Policies are intended to provide guidance in interpreting certain standard benefit plans administered by Cigna Companies. Please note, the terms of a customer's particular benefit plan document [Group Service Agreement, Evidence of Coverage, Certificate of Coverage, Summary Plan Description (SPD) or similar plan document] may differ significantly from the standard benefit plans upon which these Coverage Policies are based. For example, a customer's benefit plan document may contain a specific exclusion related to a topic addressed in a Coverage Policy. In the event of a conflict, a customer's benefit plan document always supersedes the information in the Coverage Policies. In the absence of a controlling federal or state coverage mandate, benefits are ultimately determined by the terms of the applicable benefit plan document. Coverage determinations in each specific instance require consideration of 1) the terms of the applicable benefit plan document in effect on the date of service; 2) any applicable laws/regulations; 3) any relevant collateral source materials including Coverage Policies and; 4) the specific facts of the particular situation. Each coverage request should be reviewed on its own merits. Medical directors are expected to exercise clinical judgment where appropriate and have discretion in making individual coverage determinations. Where coverage for care or services does not depend on specific circumstances, reimbursement will only be provided if a requested service(s) is submitted in accordance with the relevant criteria outlined in the applicable Coverage Policy, including covered diagnosis and/or procedure code(s). Reimbursement is not allowed for services when billed for conditions or diagnoses that are not covered under this Coverage Policy (see "Coding Information" below). When billing, providers must use the most appropriate codes as of the effective date of the submission. Claims submitted for services that are not accompanied by covered code(s) under the applicable Coverage Policy will be denied as not covered. Coverage Policies relate exclusively to the administration of health benefit plans. Coverage Policies are not recommendations for treatment and should never be used as treatment guidelines. In certain markets, delegated vendor guidelines may be used to support medical necessity and other coverage determinations.

Overview
Rytelo, an oligonucleotide telomerase inhibitor, is indicated for the treatment of **transfusion-dependent anemia** in adults with **low- to intermediate-1 risk myelodysplastic syndrome**

(MDS) requiring ≥ 4 red blood cell units over 8 weeks who have not responded to, have lost response to, or are ineligible for erythropoiesis-stimulating agents (ESAs).[1]

Discontinue if a patient does not experience a decrease in red blood cell transfusion burden after 24 weeks of treatment (administration of 6 doses) or if unacceptable toxicity occurs at any time.[1]

Dosing Information
The recommended dosage of Rytelo is 7.1 mg/kg given by a healthcare provider via intravenous infusion over 2 hours once every 4 weeks.[1]

Guidelines
The National Comprehensive Cancer Network guidelines for MDS (version 3.2026 – January 12, 2026) are extensive.[2] Rytelo is recommended for lower risk disease associated with symptomatic anemia with no del(5q) mutation with or without other cytogenetic abnormalities in certain scenarios (category 1 or category 2A). A patient is considered ring sideroblast positive (RS+) if ring sideroblasts are ≥ 15% (or ring sideroblasts ≥ 5% with an *SF3B1* mutation). A patient is considered ring sideroblast negative (RS-) if ring sideroblasts < 15% (or ring sideroblasts < 5% with an SF3B1 mutation). The guidelines categorize patients without the del(5q) abnormality on the basis of ring sideroblasts and serum erythropoietin level without specifying red blood cell transfusion burden.

- For patients who are RS- and have a serum erythropoietin ≤ 500 mU/mL, Rytelo is recommended following no response to ESAs (specifically epoetin alfa products or Aranesp) or Reblozyl® (luspatercept-aamt subcutaneous injection) [category 1]. For patients who are RS- and have a serum erythropoietin level > 500 mU/mL, Rytelo is listed as an "Other Recommended Regimen" to the preferred (azacitidine injection) [category 2A] for patients with a poor probability to respond to immunosuppressive therapy and/or following no response or an intolerance to immunosuppressive therapy.
- For patients who are RS+, Rytelo is recommended following no response to Reblozyl if serum erythropoietin levels ≤ 500 mU/mL (category 1) and if serum erythropoietin > 500 mU/mL (category 2A). For patients who are RS+ and have serum erythropoietin > 500 mU/mL, Rytelo is recommended as initial treatment as well as recommended following no response to Reblozyl (both category 2A).

Coverage Policy

Policy Statement
Prior Authorization is required for benefit coverage of Rytelo. Approval is required for those who meet the **Criteria** and **Dosing** for the listed indication. Extended approvals are allowed if the patient continues to meet the Criteria and Dosing. Requests for doses outside of the established dosing documented in this policy will be considered on a case-by-case basis by a clinician (i.e., Medical Director or Pharmacist). All approvals are provided for the duration noted below. In cases where the approval is authorized in months, 1 month is equal to 30 days. Because of the specialized skills required for evaluation and diagnosis of patients treated with Rytelo as well as the monitoring required for adverse events and long-term efficacy, approval requires Rytelo to be prescribed by or in consultation with a physician who specializes in the condition being treated.

Documentation: Documentation is required where noted in the criteria as **[documentation required]**. Documentation may include, but is not limited to, chart notes, laboratory tests, claims records, and/or other information. All documentation must include patient-specific identifying information.

Certain indications and/or approval conditions that are delegated to EviCore by Evernorth will follow Oncology Medications (1403) coverage policy for prior authorization medically necessity

criteria. Note: Any listed preferred product requirements in this coverage policy, inclusive of oncology and/or oncology-related uses, are applicable as noted.

Rytelo is considered medically necessary when the following is met:

1. **Myelodysplastic Syndrome.** Approve for the duration noted if the patient meets ONE of the following (A or B):
   - **A)** Initial Therapy. Approve for 6 months if the patient meets ALL of the following (i, ii, iii, iv, v, vi, vii and viii):
     - **i.** Patient is ≥ 18 years of age; AND
     - **ii.** According to the prescriber, patient has very low to intermediate-risk risk myelodysplastic syndrome (MDS); AND
       Note: MDS risk category is determined using the International Prognostic Scoring System (IPSS).
     - **iii.** Patient does not have a confirmed mutation with deletion 5q [del(5q)] **[documentation required]**; AND
     - **iv.** According to the prescriber, the patient has symptomatic anemia; AND
     - **v.** Rytelo will NOT be used in combination with an erythropoiesis stimulating agent; AND
     - **vi.** The medication is being prescribed by or in consultation with an oncologist or hematologist; AND
     - **vii.** Preferred product criteria is met for the product(s) as listed in the below table(s) OR
   - **B)** Patient is Currently Receiving Rytelo. Approve for 1 year if, according to the prescriber, the patient has experienced a clinically meaningful decrease in transfusion burden.
     Note: For a patient who has not received 6 months (24 weeks) of therapy or who is restarting therapy, refer to Initial Therapy criteria above.

   Dosing. Approve up to 7.1 mg/kg by intravenous infusion administered not more frequently than once every 4 weeks.

Employer Plans:

Product	Criteria
Rytelo (imetelstat intravenous infusion)	Approve if the patient meets ONE of the following (1, 2 or 3): 1. Patient has tried Reblozyl (luspatercept) **[documentation required]** 2. Patient is ineligible for erythropoiesis-stimulating agents; OR Note: An example is a patient with a serum EPO level > 500 mU/mL. 3. Patient has already been started on therapy with Rytelo

Individual and Family Plans:

Product	Criteria
Rytelo (imetelstat intravenous infusion)	Approve if the patient meets ONE of the following (1, 2 or 3): 1. Patient has tried Reblozyl (luspatercept) **[documentation required]** 2. Patient is ineligible for erythropoiesis-stimulating agents; OR Note: An example is a patient with a serum EPO level > 500 mU/mL. 3. Patient has already been started on therapy with Rytelo

Conditions Not Covered

Rytelo for any other use is considered not medically necessary. Criteria will be updated as newly published data are available.

Coding Information

Note: 1) This list of codes may not be all-inclusive.
2) Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement.

Considered Medically Necessary when criteria in the applicable policy statements listed above are met:

HCPCS Codes	Description
J0870	Injection, imetelstat, 1 mg

References

1. Rytelo® intravenous infusion [prescribing information]. Foster City, CA: Geron; June 2024.
2. The NCCN Myelodysplastic Syndromes Clinical Practice Guidelines in Oncology (version 3.2026 – January 12, 2026). © 2026 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed on January 26, 2026.

Revision Details

Type of Revision	Summary of Changes	Date
New	New policy	10/1/2024
Selected Revision	**Preferred Product Table:** **Added** a prerequisite step through Reblozyl prior to coverage of Rytelo, for both Employer and Individual and Family Plans.	11/1/2024
Selected Revision	**Updated Coding:** **Added:** J9399, J3490, J9999 (Codes effective until 12/31/2024) **Added:** J0870 (Code effective 1/1/2025)	1/1/2025
Annual Revision	No criteria changes.	9/1/2025
Annual Revision	**Added** documentation instructions **Myelodysplastic Syndrome:** Regarding the diagnosis of myelodysplastic syndrome, the qualifier of "very" was added to "low" and "intermediate-1" was changed to "intermediate". Also, removed the requirement that the patient does not have deletion 5q [del{5q)] cytogenic abnormality. In the requirement that the patient has responded, lost response, or is ineligible for erythropoiesis-stimulating agents, a Note was added that a patient with a serum erythropoietin level > 500 mU/mL is considered ineligible for erythropoiesis-stimulating agents.	1/15/2026

	Preferred Product Table. **Added** documentation requirements **Removed** "Patient does NOT have a deletion 5q; Patient has ring sideroblasts < 15%, patient has tried or has a poor probability to respond to immunosuppressive therapy. **Added** "Patient is ineligible for erythropoiesis-stimulating agents; Note: An example is a patient with a serum EPO level > 500 mU/mL; Patient has tried lenalidomide. **Updated** policy template **Coding Information** Removed HCPCS codes: C9399 J3490 & J3590 Removed "code effective date 1/1/25" from J0870	
Annual Revision	**Myelodysplastic Syndrome:** For initial, therapy the following requirements were removed: patient has transfusion-dependent anemia, defined as requiring transfusion of ≥ 4 red blood cell units over an 8-week period, and according to the prescriber, patient has not responded, lost response to, or is ineligible for erythropoiesis-stimulating agents along with the note of examples of erythropoiesis-stimulating agents. The following requirements were added: Patient does not have a confirmed mutation with deletion 5q [del(5q)], and according to the prescriber, the patient has symptomatic anemia **[documentation required]**. **Preferred Product Table.** **Removed** "Patient has tried lenalidomide" for Employer Plans and Individual and Family Plans	4/1/2026

The policy effective date is in force until updated or retired.