

Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
REBLOZYL (Luspatercept) Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk
Length of Authorizations: Initial- 6 months; Continuation- 6 months

Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **REBLOZYL** (Luspatercept). <u>Please complete all sections, incomplete forms will delay processing.</u> <u>Fax this form back to Kaiser Permanente within 24 hours fax: 1-866-331-2104</u>. If you have any questions or concerns, please call 1-866-331-2103. **Requests will not be considered unless all sections are complete.**

KP-MAS Formulary can be found at: http://www.providers.kaiserpermanente.org/mas/formulary.html

	1 – Patient Information	
Patient Name:	Kaiser Medical ID#:	Date of Birth:
	2 – Prescriber Information	
Is the prescriber a Hematology-Onco	ology Specialist? □ No □ Yes	
If consulted with a specialist, special	ist name and specialty:	
Prescriber Name:	Specialty:	NPI:
Prescriber Address:		
Prescriber Phone #:	Prescriber Fax #:	
3 – Pharmacy Information		
Pharmacy Name:	Pharmacy NPI:	
Pharmacy Phone #	Pharmacy Fax #:	
	4 – Drug Therapy Requested	
Drug 1: Name/Strength/Formulation	1:	
Drug 2: Name/Strength/Formulation	ı:	
Sig:		

5- Diagnosis/Clinical Criteria

1.	Is this request for initial or continuing therapy?	
	□ Initial therapy □ Continuing therapy, State date:	
2.	Indicate the Member's diagnosis for the requested medication:	
	Is the member ≥18 years of age? AND	
	□ No □ Yes	
4.	Is the member diagnosed with beta thalassemia or hemoglobin E/beta thalassemia? AND □ No □ Yes	
5.	Is there documentation of receiving regular transfusions (defined as 6 or 20 RBC units in the 24 weeks prior to treatment initiation and no transfusion-free period for ≥35 days during that period)? AND □ No □ Yes	
6.	Is there documentation of the following?	
	a. Number of RBC transfusions within prior 6 months	
	b. Baseline hemoglobin	
	□ No □ Yes	
	Reassess every 6 months to determine need for continued therapy; therapy should be discontinued if the member meets any of the following criteria: a. No clinically meaningful decrease in transfusions on maximum recommended dose b. Non-adherence to the medication □ No □ Yes	
6 – Prescriber Sign-Off		
Additio	onal Information – Please submit chart notes/medical records for the patient that are applicable to this request.	
Provid	e any additional supporting information that should be taken into consideration:	
l cert	ify that the information provided is accurate. Supporting documentation is available for State audits.	
	ber Signature: Date:	
	lote: This document contains confidential information, including protected health information, intended for a specific individual and purpose. The information is and legally protected by law, including HIPAA. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or taking of	
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