Reference number(s)
6523-A

Standard Medicare Part B Management Rytelo

Products Referenced by this Document

Drugs that are listed in the following table include both brand and generic and all dosage forms and strengths unless otherwise stated. Over-the-counter (OTC) products are not included unless otherwise stated.

Brand Name	Generic Name
Rytelo	imetelstat

Indications

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

FDA-Approved Indication[1]

Rytelo is indicated for adult patients with low- to intermediate-1 risk myelodysplastic syndromes (MDS) with transfusion-dependent anemia requiring 4 or more red blood cell units over 8 weeks who have not responded to or have lost response to or are ineligible for erythropoiesis-stimulating agents (ESAs).

Compendial Use[2]

Myelodysplastic syndromes (MDS)

All other indications will be assessed on an individual basis. Submissions for indications other than those listed in this criteria should be accompanied by supporting evidence from Medicare approved compendia.

Coverage Criteria

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Myelodysplastic Syndromes (MDS)[1,2]

Authorization of 24 weeks may be granted for treatment of lower risk (e.g., International Prognostic Scoring System-Revised [IPSS-R] very low, low, and intermediate risk) myelodysplastic syndromes (MDS) with transfusion-dependent anemia when both of the following criteria are met:

- Member meets one of the following:
  - The member has not responded to, has lost response to, or is ineligible (e.g., serum erythropoietin (sEPO) greater than 500 mU/mL) for erythropoiesis-stimulating agents (ESAs).
  - The member has not responded to or has lost response to luspatercept-aamt (Reblozyl).
- The member has been receiving regular red blood cell (RBC) transfusions as defined by greater than or equal to 4 units per 8 weeks.

Continuation of Therapy

All members (including new members) requesting authorization for continuation of therapy must be currently receiving therapy with the requested medication.

Authorization for 6 months may be granted when all of the following criteria are met:

- The member is currently receiving therapy with the requested medication.
- The requested medication is being used to treat an indication listed in the coverage criteria section
- The member is receiving benefit from therapy. Benefit is defined as:
  - Achieving or maintaining red blood cell transfusion burden reduction, AND
  - No evidence of unacceptable toxicity while on the current regimen.

Summary of Evidence

The contents of this policy were created after examining the following resources:

- The prescribing information for Rytelo.
- The available compendium
  - National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium
  - Micromedex DrugDex
  - American Hospital Formulary Service- Drug Information (AHFS-DI)
  - Lexi-Drugs
  - Clinical Pharmacology

Explanation of Rationale

Support for FDA-approved indications can be found in the manufacturer's prescribing information.

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Support for using Rytelo for myelodysplastic syndromes (MDS) can be found in the NCCN Drugs and Biologics Compendium. Use of information in the NCCN Drugs and Biologics Compendium for off-label use of drugs and biologicals in an anti-cancer chemotherapeutic regimen is supported by the Medicare Benefit Policy Manual, Chapter 15, section 50.4.5 (Off-Label Use of Drugs and Biologicals in an Anti-Cancer Chemotherapeutic Regimen).

References

1. Rytelo [package insert]. Foster City, CA: Geron Corporation; June 2024.
2. The NCCN Drugs & Biologics Compendium® © 2026 National Comprehensive Cancer Network, Inc. Available at: http://www.nccn.org. Accessed January 14, 2026.

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