NOVA SCOTIA PROVINCIAL PHARMACARE PROGRAMS

Request for Insured Coverage of Luspatercept (Reblozyl)

PATIENT INFORMATION			
PATIENT SURNAME	PATIENT GIVEN NAME	HEALTH CARD NUMBER	DATE OF BIRTH
PATIENT ADDRESS			

Reblozyl Start Date*: ______________________________

*If the patient has been established on Reblozyl therapy prior to an initial request for coverage, please complete both the Initial and Renewal Request Sections

DIAGNOSIS

Beta-Thalassemia Anemia	Myelodysplastic Syndromes
Initial Request	**Initial Request**
For the treatment of adult patients who have: ☐ RBC transfusion-dependent anemia associated with beta-thalassemia **Patients must be receiving regular transfusions, defined as:** ☐ 6 to 20 RBC units in the 24 weeks prior to initiating treatment with luspatercept **Number of RBC units required:** _____________ **AND** ☐ No transfusion-free period greater than 35 days in the 24 weeks prior to initiating treatment with luspatercept	**For the treatment of adult patients who have:** ☐ Red blood cell (RBC) transfusion–dependent anemia associated with very low- to intermediate-risk MDS **AND** ☐ Ring sideroblasts **AND** ☐ Failed or are not suitable for erythropoietin-based therapy
Renewal Requests	**Renewal Requests**
<u>Initial Renewal</u> **Patients must demonstrate an initial response, defined as:** ☐ A ≥33% reduction in transfusion burden (RBC units/time) compared to the pre-treatment baseline RBC transfusion burden, measured over 24 weeks prior to initiating treatment with luspatercept **Number of RBC units required:** _____________ **<u>Subsequent Renewals</u>** ☐ Patient maintains a reduction in transfusion burden of ≥33% compared to the pre-luspatercept transfusion burden **Number of RBC units required:** _____________ Luspatercept should be discontinued if a patient does not respond after nine weeks of treatment (three doses) at the maximum dose.	**<u>Initial Renewal</u>** **Patients should be:** ☐ RBC transfusion independent over a minimum of 16 consecutive weeks within the first 24 weeks of treatment initiation **<u>Subsequent Renewals</u>** **For continued coverage, patients should be:** ☐ RBC transfusion independent over a minimum of 16 consecutive weeks within the previous approval period
PRESCRIBER NAME & ADDRESS: LICENCE #	PRESCRIBER SIGNATURE DATE

If you need assistance, please contact the Pharmacare Office at (902) 496-7001 or 1-800-305-5026

Please Return Form To: Nova Scotia Pharmacare Programs
P.O. Box 500, Halifax, NS B3J 2S1, Fax: (902) 496-4440