Clinical Policy: Erwinia Asparaginase (Rylaze)

Reference Number: PA.CP.PHAR.301
Effective Date: 01/2018
Last Review Date: 01/2024

Coding Implications
Revision Log

Description
Asparaginase *Erwinia chrysanthem* (recombinant)-rywn (Rylaze™) is an asparagine specific enzyme.

FDA Approved Indication(s)
Rylaze is indicated as a component of a multi-agent chemotherapeutic regimen for the treatment of ALL and lymphoblastic lymphoma (LBL) in adult and pediatric patients 1 month or older who have developed hypersensitivity to *E. coli*-derived asparaginase.

Policy/Criteria
Provider must submit documentation (including 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 Rylaze are **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Acute Lymphoblastic Leukemia (must meet all):
1. Diagnosis of acute lymphoblastic leukemia (ALL);
2. Prescribed by or in consultation with an oncologist or hematologist;
3. Age ≥ 1 month;
   a.
4. Prescribed as a component of a multi-agent chemotherapeutic regimen;
5. Member has developed hypersensitivity to an *E. coli* derived asparaginase product (Elspar® - off-market), pegaspargase (Oncaspar®) or calaspargase pegol-mknl (Asparlas®);
6. Request meets one of the following (a, b, or c):
   a. Dose does not exceed 25 mg/ m^2 every 48 hours;
   b. Dose does not exceed 25 mg/m^2 on Monday and Wednesday and 50 mg/m^2 on Friday;
   c. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use *(prescriber must submit supporting evidence).*

Approval duration: 3 months

B. Lymphoblastic Lymphoma (must meet all)**:**
1. Diagnosis of LBL;
2. Prescribed by or in consultation with an oncologist or hematologist;
3. Age ≥ 1 month;
4. Prescribed as a component of a multi-agent chemotherapeutic regimen;
5. Member has developed hypersensitivity to an *E. coli* derived asparaginase product (Elspar - off-market) or pegaspargase (Oncaspar);
6. Request meets one of the following (a, b or c):

a. Dose does not exceed 25 mg/ m^2 every 48 hours;
b. Dose does not exceed 25 mg/m2 on Monday and Wednesday and 50 mg/m2 on Friday;
c. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use *(prescriber must submit supporting evidence).*

Approval duration: 3 months

C. T-Cell Lymphoma (off-label) (must meet all)**:**
1. Diagnosis of extranodal NK/T-cell lymphoma;
2. Prescribed by or in consultation with an oncologist or hematologist;
3. Age ≥ 1 month;
4. Member has developed hypersensitivity to an *E. coli* derived asparaginase product (Elspar - off-market) or pegaspargase (Oncaspar);
5. Dose is within FDA maximum limit for any FDA-approved indication or is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

Approval duration: 3 months

D. Other diagnoses/indications: Refer to PA.CP.PMN.53

II. Continued Approval

A. All Indications in Section I(must meet all)**:**
1. Currently receiving medication via PA Health & Wellness benefit or member has previously met all initial approval criteria; or the Continuity of Care policy (PA.LTSS.PHAR.01) applies;
2. Member is responding positively to therapy;
3. If request is for a dose increase, request meets one of the following (a, b, or c):
   a. NDose does not exceed 25 mg/ m^2 every 48 hours;
   b. Dose does not exceed 25 mg/m^2 on Monday and Wednesday and 50 mg/m^2 on Friday;
   c. New 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.LTSS.PHAR.01) applies.
   Approval duration: Duration of request or 6 months (whichever is less); or
2. Refer to PA.CP.PMN.53

III. Appendices/General Information

Appendix A: Abbreviation/Acronym Key
ALL: acute lymphoblastic leukemia
FDA: Food and Drug Administration
LBL: lymphoblastic lymphoma

Appendix B: Therapeutic Alternatives
Not applicable

Appendix C: Contraindications/Boxed Warnings

- Contraindication(s): History of serious hypersensitivity reactions to Rylaze, including anaphylaxis, serious pancreatitis with prior L-asparaginase therapy, serious thrombosis with prior L-asparaginase therapy, serious hemorrhagic events with prior L-asparaginase therapy.
- Boxed warning(s): None reported.

IV. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
ALL, LBL	When replacing a long-acting asparginase product the recommended dose is: • 25 mg/m^2 IM every 48 hours OR • 25 mg/m^2 IM on Monday morning and Wednesday morning, and 50 mg/m^2 IM on Friday afternoon	50 mg/m^2/dose

V. Product Availability

Single-dose vial for injection: 10 mg/0.5 ml

VI. References

1. Rylaze Prescribing Information. Palo Alto, CA: Jazz Pharmaceuticals, Inc.; November 2022. Available at: https://pp.jazzpharma.com/pi/rylaze.en.USPI.pdf. Accessed October 16, 2023.
2. National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at ww.nccn.org/professionals/drug_compendium. Accessed November 15, 2023.
3. National Comprehensive Cancer Network. Acute Lymphoblastic Leukemia Version 3.2023. Available at: https://www.nccn.org/professionals/physician_gls/pdf/all.pdf. Accessed November 22, 2023.
4. National Comprehensive Cancer Network. Pediatric Acute Lymphoblastic Leukemia Version 3.2024. Available at: https://www.nccn.org/professionals/physician_gls/pdf/ped_all.pdf. Accessed November 22, 2023.
5. National Comprehensive Cancer Network. T-Cell Lymphomas Version 1.2023. Available at: https://www.nccn.org/professionals/physician_gls/pdf/t-cell.pdf. Accessed November 22, 2023.

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
J9019	Injection, asparaginase, (Erwinaze), 1,000 IU

HCPCS Codes	Description
J9020	Injection, asparaginase, not otherwise specified, 10,000 units
J9021	Injection, asparaginase, recombinant, (Rylaze), 0.1 mg

Reviews, Revisions, and Approvals	Date
Combined FDA approved criteria and NCCN recommendations, FDA indication covers both. References reviewed and updated	02/2018
1Q 2019 annual review; specialist added; per Recordati Rare Diseases, who acquired Elspar from Lundbeck in January 2013, Elspar was discontinued in 2012, there are currently no plans to reintroduce Elspar, there is no residual Elspar supply remaining on the current market, and Recordati Rare Diseases has not provided Elspar to any other territory within the global market; references reviewed and updated.	01/2019
1Q 2020 annual review: induction therapy added per NCCN for members 65 or older; references reviewed and updated.	01/2020
1Q 2021 annual review: Oncospar dosing updated; references reviewed and updated.	01/2021
RT4: added Rylaze to policy with new criteria set for LBL indication	10/2021
1Q 2022 annual review: specified only Erwinaze recommended for ALL induction therapy per NCCN; references reviewed and updated.	01/2022
1Q 2023 annual review: added age requirements for ALL and LBL indication; added usage of Erwinaze for ALL for those age ≥18 years with substantial comorbidities per NCCN; added criterion for T-cell lymphoma per NCCN; references reviewed and updated.	01/2023
1Q 2024 annual review: for ALL, added Asparlas to criteria that member was developed hypersensitivity to; removed discontinued Erwinaze product from policy; references reviewed and updated.	01/2024