Prior Authorization Review Panel

CHC-MCO Policy Submission

A separate copy of this form must accompany each policy submitted for review.
Policies submitted without this form will not be considered for review.

Plan: PA Health & Wellness	**Submission Date: 11/01/2021**
Policy Number: PA.CP.PHAR.301	**Effective Date: 01/01/2018** **Revision Date: 10/2021**
Policy Name: Erwinia Asparaginase (Erwinaze, Rylaze)	

Type of Submission – Check all that apply:

- ☐ **New Policy**
- ✓ **Revised Policy***
- ☐ **Annual Review - No Revisions**
- ☐ **Statewide PDL -** *Select this box when submitting policies for Statewide PDL implementation and when submitting policies for drug classes included on the Statewide PDL.*

***All revisions to the policy must be highlighted using track changes throughout the document.**

Please provide any changes or clarifying information for the policy below:

RT4: added Rylaze to policy with new criteria set for LBL indication

Name of Authorized Individual (Please type or print): **Venkateswara R. Davuluri, MD**	**Signature of Authorized Individual:**

Clinical Policy: Erwinia Asparaginase (Erwinaze, Rylaze)

Reference Number: PA.CP.PHAR.301
Effective Date: 01/2018
Last Review Date: 10/2021

Coding Implications
Revision Log

Description
Asparaginase *Erwinia chrysanthemi* (Erwinaze®) and asparaginase *Erwinia chrysanthem* (recombinant)-rywn (Rylaze™) are asparagine specific enzymes.

FDA Approved Indication(s)
Erwinaze is indicated as a component of a multi-agent chemotherapeutic regimen for the treatment of patients with acute lymphoblastic leukemia (ALL) who have developed hypersensitivity to *E. coli*-derived asparaginase.

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 Pennsylvania Health and Wellness ® that Erwinaze and 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. Prescribed as a component of a multi-agent chemotherapeutic regimen;
4. Member meets (a or b):
   a. Member has developed hypersensitivity to an *E. coli* derived asparaginase product (Elspar® - off-market) or pegaspargase (Oncaspar®);
   b. Age ≥ 65 years and prescribed as combination induction therapy;
5. Request meets one of the following (a, b, or c):*
   a. Erwinaze: dose does not exceed 25,000 International Units/m^2 administered three times per week;
   b. Rylaze: dose does not exceed 25 mg/ m^2 every 48 hours;
   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. Request is for Rylaze;
3. Prescribed by or in consultation with an oncologist or hematologist;
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 or b):
   a. Dose does not exceed 25 mg/ m^2 every 48 hours;
   b. 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. 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 Pennsylvania Health and 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. Erwinaze: new dose should not exceed 25,000 International Units per m^2 administered three times per week;
   b. Rylaze: new dose does not exceed 25 mg/ m^2 every 48 hours;
   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 Pennsylvania Health and 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
This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent for all relevant lines of business and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Oncaspar (pegaspargase)	• Administered IM or IV no more frequently than every 14 days.	Varies

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
	• Patients ages 21 years and younger: 2,500 International Units/m^2. • Patients ages over 21 years: 2,000 International Units/m^2. • For IM administration, limit the volume at a single injection site to 2 mL; if greater than 2 mL, use multiple injection sites. • For IV administration, give over a period of 1 to 2 hours in 100 mL of 0.9% Sodium Chloride Injection, USP or 5% Dextrose Injection, USP through an infusion that is already running. • Do not administer Oncaspar if drug has been frozen, stored at room temperature for more than 48 hours, or shaken or vigorously agitated.	

Therapeutic alternatives are listed as Brand name® (generic) when the drug is available by brand name only and generic (Brand name®) when the drug is available by both brand and generic.

Appendix C: Contraindications/Boxed Warnings

- Contraindication(s): History of 1) serious hypersensitivity reactions to Erwinaze/Rylaze, including anaphylaxis, 2) serious pancreatitis with prior L-asparaginase therapy, 3) serious thrombosis with prior L-asparaginase therapy, 4) serious hemorrhagic events with prior L-asparaginase therapy.
- Boxed warning(s): None reported.

IV. Dosage and Administration

Drug Name	Indication	Dosing Regimen	Maximum Dose
Erwinaze	ALL	To substitute for pegaspargase: the recommended dose for each planned dose of pegaspargase is 25,000 International Units/m^2 administered IM or IV TIW (Monday/Wednesday/Friday) for six doses.	25,000 IU/m^2/dose
Rylaze	ALL, LBL	To substitute for pegaspargase: 25 mg/m^2 IM every 48 hours to complete the intended duration of pegaspargase therapy	25 mg/m^2/dose

V. Product Availability

Drug Name	Availability
Erwinaze	10,000 International Units lyophilized powder per vial
Rylaze	10 mg/0.5 ml solution in single-dose vial

VI. References

1. Erwinaze Prescribing Information. Palo Alto, CA: Jazz Pharmaceuticals, Inc.; December 2019. Available at https://pp.jazzpharma.com/pi/erwinaze.en.USPI.pdf. Accessed October 12, 2020.
2. Rylaze Prescribing Information. Palo Alto, CA: Jazz Pharmaceuticals, Inc.; June 2021. Available at: https://www.accessdata.fda.gov/drugsatfda_docs/label/2021/761179s000lbl.pdf. Accessed July 13, 2021.
3. Oncaspar Prescribing Information. Gaithersburg, MD: Sigma-Tau Pharmaceuticals, Inc.; August 2019. Available at https://www.oncaspar.com/prescribing_information.pdf. Accessed October 12, 2020.
4. National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at ww.nccn.org. Accessed July 13, 2021.
5. Acute Lymphoblastic Leukemia Version 1.2021. National Comprehensive Cancer Network Guidelines. Available at www.nccn.org. Accessed July 13, 2021.
6. Pediatric Acute Lymphoblastic Leukemia Version 2.2021. National Comprehensive Cancer Network Guidelines. Available at www.nccn.org. Accessed July 13, 2021.
7. B-Cell Lymphomas Version 4.2021. National Comprehensive Cancer Network Guidelines. Available at https://www.nccn.org/professionals/physician_gls/pdf/b-cell.pdf. Accessed July 13, 2021.

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
J9020	Injection, asparaginase, not otherwise specified, 10,000 units

Reviews, Revisions, and Approvals	Date	Approval Date
Combined FDA approved criteria and NCCN recommendations, FDA indication covers both. References reviewed and updated	02/18	
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.	01/19	
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	