# Clinical Policy: Erwinia Asparaginase (Erwinaze, Rylaze)

**Reference Number: LA.PHAR.301**
**Effective Date:**
**Last Review Date: 08.22**
**Line of Business: Medicaid**

**Coding Implications**
**Revision Log**

**See Important Reminder at the end of this policy for important regulatory and legal information.**

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
*Prior authorization is required. 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 Louisiana Healthcare Connections 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 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. For Erwinaze, 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).*

  **Prescribed regimen must be FDA-approved or recommended by NCCN.*

Approval duration:
Medicaid – 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).*

**Prescribed regimen must be FDA-approved or recommended by NCCN.*

Approval duration:
Medicaid – 3 months

**C.** Other diagnoses/indications
1. Refer to the off-label use policy if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): LA.PMN.53 for Medicaid.

**II.** Continued Therapy

**A.** All Indications in Section I (must meet all):
1. Currently receiving medication via Louisiana Healthcare Connections benefit, or documentation supports that member is currently receiving Erwinaze or Rylaze for a covered indication and has received this medication for at least 30 days;
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).*

**Prescribed regimen must be FDA-approved or recommended by NCCN.*

Approval duration:
Medicaid – 6 months

**B.** Other diagnoses/indications (must meet 1 or 2):
1. Currently receiving medication via Louisiana Healthcare Connections benefit and documentation supports positive response to therapy.

Approval duration: Duration of request or 6 months (whichever is less); or

2. Refer to the off-label use policy if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): LA.PMN.53 for Medicaid.

**III.** Diagnoses/Indications for which coverage is NOT authorized:

**A.** Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off- label use policy – LA.PMN.53 for Medicaid, or evidence of coverage documents.

**IV.** 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 require prior authorization.*

| Drug Name | Dosing Regimen | Dose Limit/ Maximum Dose |
|---|---|---|
| Oncaspar (pegaspargase) | • Administered IM or IV no more frequently than every 14 days.<br>• Patients ages 21 years and younger: 2,500 International Units/$m^2$.<br>• Patients ages over 21 years: 2,000 International Units/$m^2$. | Varies |

*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.

**V.** 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 | 25,000 IU/$m^2$/dose |

| Drug Name | Indication | Dosing Regimen | Maximum Dose |
|---|---|---|---|
| | | IV TIW (Monday/Wednesday/Friday) for six doses. | |
| 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 |

**VI.** 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 |

**VII.** 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 November 10, 2021.
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 November 10, 2021.
3. Oncaspar Prescribing Information. Boston, MA: Servier Pharmaceuticals LLC.; June 2020. Available at https://www.oncaspar.com/prescribing_information.pdf. Accessed November 10, 2021.
4. National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at ww.nccn.org. Accessed November 10, 2021.
5. Acute Lymphoblastic Leukemia Version 2.2021. National Comprehensive Cancer Network Guidelines. Available at www.nccn.org. Accessed November 10, 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 | LDH Approval Date |
|---|---|---|
| Converted corporate to local policy. | 09.22 | |

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. LHCC makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable LHCC administrative policies and procedures.

This clinical policy is effective as of the date determined by LHCC. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. LHCC retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom LHCC has no control or right of control. Providers are not agents or employees of LHCC.