

Clinical Policy: Sirolimus Protein-Bound Particles (Fyarro)

Reference Number: LA.PHAR.574

Effective Date: 09.29.23

Last Review Date: 02.13.26

Line of Business: Medicaid

[Coding Implications](#)

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

****Please note: This policy is for medical benefit****

Description

Sirolimus protein-bound particles (Fyarro™) is a mammalian target of rapamycin (mTOR) inhibitors.

FDA Approved Indication(s)

Fyarro is indicated for the treatment of adult patients with locally advanced unresectable or metastatic malignant perivascular epithelioid cell tumor (PEComa).

Policy/Criteria

Provider must submit documentation (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 Fyarro is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Perivascular Epithelioid Cell Tumor (PEComa) (must meet all):

1. Diagnosis of locally advanced unresectable or metastatic malignant perivascular epithelioid cell tumor (PEComa);
2. Request is for Fyarro;
3. Prescribed by or in consultation with an oncologist;
4. Age \geq 18 years;
5. Use as a single agent;
6. Member does not have PEComa type lymphangiomyomatosis;
7. Request meets one of the following (a or b):*
 - a. Dose does not exceed 100 mg/m² IV on Days 1 and 8 of each 21 day cycle;
 - 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: 12 months

B. Other diagnoses/indications (must meet 1 or 2):

CLINICAL POLICY

Sirolimus

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to LA.PMN.255
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy LA.PMN.53.

II. Continued Therapy

A. Perivascular Epithelioid Cell Tumor (PEComa) (must meet all):

1. Currently receiving medication via Louisiana Healthcare Connections benefit, or documentation supports that member is currently receiving Fyarro for a covered indication and has received this medication for at least 30 days;
2. Request is for Fyarro;
3. Member is responding positively to therapy;
4. If request is for a dose increase, request meets one of the following (a or b):*
 - a. Both of the following (i and ii):
 - i. New dose does not exceed 100 mg/m² IV on Days 1 and 8 of each 21 day cycle;
 - ii. Dose is at least 45 mg/m² IV on Days 1 and 8 of each 21 day cycle;
 - b. 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: 12 months

B. Other diagnoses/indications (must meet 1 or 2):

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to LA.PMN.255
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for LA.PMN.53.

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.

CLINICAL POLICY

Sirolimus

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

FDA: Food and Drug Administration

NCCN: National Comprehensive Cancer Network

PEComa: perivascular epithelioid cell tumor

Appendix B: Therapeutic Alternatives

Not Applicable

Appendix C: Contraindications/Boxed Warnings

- Contraindication(s): History of severe hypersensitivity to sirolimus, other rapamycin derivatives, or albumin.
- Boxed warning(s): None reported

V. Dosage and Administration

Drug Name	Indication	Dosing Regimen	Maximum Dose
Sirolimus protein-bound particles (Fyarro)	Locally advanced unresectable or metastatic malignant PEComa	100 mg/m ² administered as an IV infusion over 30 minutes on Days 1 and 8 of each 21-day cycle until disease progression or unacceptable toxicity	100 mg/m ² administered as an IV infusion over 30 minutes on Days 1 and 8 of each 21-day cycle

VI. Product Availability

Drug Name	Availability
Sirolimus protein-bound particles (Fyarro)	Lyophilized powder for infusion: 100 mg of sirolimus formulated as albumin-bound particles in single-dose vial for reconstitution

VII. References

1. Fyarro Prescribing Information. Pacific Palisades, CA. Aadi Bioscience, Inc; December 2024. Available at: <https://www.fyarro.com/images/prescribing/prescribing-information.pdf>. Accessed October 23, 2025.
2. Hyftor Prescribing Information. Bethesda, MD. Nobelpharma America, LLC; May 2025 Available at: https://www.hyftor.com/wp-content/uploads/2025/07/HYFTOR_Prescribing_Information.pdf. Accessed October 23, 2025.
3. National Comprehensive Cancer Network. Soft Tissue Sarcoma Version 1.2025. Available at: https://www.nccn.org/professionals/physician_gls/pdf/sarcoma.pdf. Accessed November 17, 2025.

CLINICAL POLICY

Sirolimus

4. National Comprehensive Cancer Network. Uterine Neoplasms Version 2.2026. Available at: https://www.nccn.org/professionals/physician_gls/pdf/uterine.pdf. Accessed November 17, 2025.
5. ClinicalTrials.gov. A Phase 2 Study of ABI-009 in Patients with Advanced Malignant PEComa (AMPECT). Available at: <https://www.clinicaltrials.gov/ct2/show/NCT02494570>. Accessed November 17, 2025.
6. Bissler JJ, McCormack FX, Young LR et al. Sirolimus for Angiomyolipoma in Tuberous Sclerosis complex or Lymphangiomyomatosis. The New England Journal of Medicine. 2008; 358:140-51.
7. Wagner AJ, Malinowska-Kolodziej I, Morgan JA et al. Clinical Activity of mTOR Inhibition with Sirolimus in Malignant Perivascular Epithelioid Cell Tumors: Targeting the Pathogenic Activation of mTORC1 in Tumors. Journal of Clinical Oncology. 2010; DOI: 10.1200/JCO.2009.25.2981.
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9. Northrup H, Aronow ME, Bebin EM, et al. International Tuberous Sclerosis Complex Consensus Group. Updated International Tuberous Sclerosis Complex Diagnostic Criteria and Surveillance and Management Recommendations. Pediatr Neurol. 2021 Oct;123:50-66.

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
J9331	Injection, sirolimus protein-bound particles (Fyarro), 1 mg

Reviews, Revisions, and Approvals	Date	LDH Approval Date
Policy created.	05.01.23	08.28.23
Annual review: no significant changes; references reviewed and updated.	04.05.24	07.10.24
Annual review: no significant changes; references reviewed and updated.	02.06.25	05.19.25
Annual review: revised initial approval duration to 12 months; references reviewed and updated.	02.13.26	

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

CLINICAL POLICY

Sirolimus

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CLINICAL POLICY

Sirolimus

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