Clinical Policy: Erwinia Asparaginase (Rylaze)

Reference Number: LA.PHAR.301
Effective Date: 10.05.23
Last Review Date: 05.27.24
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

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 Louisiana HealthCare Connections® that Rylaze is **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. 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), 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).*

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

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, 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).*

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

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 ≥ 18 years;
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*).*

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

Approval duration: 3 months

D. 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.53
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. 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 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. 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. 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: 6 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
   Approval duration: Duration of request or 6 months (whichever is less); or
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 off-label use policy 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

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
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.

V. 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	50 mg/m^2/dose

Indication	Dosing Regimen	Maximum Dose
	• 25 mg/m^2 IM on Monday morning and Wednesday morning, and 50 mg/m^2 IM on Friday afternoon	

VI. Product Availability

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

VII. 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
J9020	Injection, asparaginase, not otherwise specified, 10,000 units
J9021	Injection, asparaginase, recombinant, (Rylaze), 0.1 mg

Reviews, Revisions, and Approvals	Date	LDH Approval Date
Converted corporate to local policy	09.22	10.30.22
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; For ALL and LBL, added Rylaze MWF dosing regimen. References reviewed and updated.	06.27.23	10.05.23

Reviews, Revisions, and Approvals	Date	LDH Approval Date
Template changes applied to other diagnoses/indications. Added blurb this policy is for medical benefit only. Added HCPCS Code J0921.		
For ALL, added Asparlas to criteria that member was developed hypersensitivity to; removed discontinued Erwinaze product from policy; references reviewed and updated.	05.27.24	

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.