Clinical Policy: Pegaspargase (Oncaspar), Calaspargase Pegol-mknl (Asparlas)

Reference Number: CP.PHAR.353
Effective Date: 09.05.17
Last Review Date: 11.22
Line of Business: Commercial, HIM, Medicaid

Coding Implications
Revision Log

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

Description

Pegaspargase (Oncaspar®) and calaspargase pegol-mknl (Asparlas™) are asparagine specific enzymes.

FDA Approved Indication(s)

Oncaspar is indicated as a component of a multi-agent chemotherapeutic regimen for the treatment of pediatric and adult patients with:

- Acute lymphoblastic leukemia (ALL), as first-line treatment
- ALL and hypersensitivity to native forms of L-asparaginase

Asparlas is indicated as a component of a multi-agent chemotherapeutic regimen for the treatment of ALL in pediatric and young adult patients age 1 month to 21 years.

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 health plans affiliated with Centene Corporation® that Oncaspar and Asparlas 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. If request is for Asparlas, age 1 month to ≤ 21 years;
4. Prescribed as part of a multi-agent chemotherapeutic regimen;
5. Request meets one of the following (a, b, or c):*
   a. Oncaspar: Dose does not exceed 2,500 IU/m^2 every 14 days (age ≤ 21 years) or 2,000 IU/m^2 every 14 days (age > 21 years);
   b. Asparlas: Dose does not exceed 2,500 units/m^2 every 21 days;
   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: 6 months

B. T-Cell Lymphoma (off-label) (must meet all)**:**
1. Diagnosis of one of the following (a or b):
   a. Extranodal NK/T-cell lymphoma;
   b. Hepatosplenic T-cell lymphoma;
2. Request is for Oncaspar;
3. Prescribed by or in consultation with an oncologist or hematologist;
4. Age ≥ 18 years;
5. Prescribed as a component of any of the following regimens (a, b, c, or d):*
   a. Modified-SMILE (steroid [dexamethasone], methotrexate, ifosfamide, pegaspargase, etoposide);
   b. P-GEMOX (gemcitabine, pegaspargase, oxaliplatin);
   c. DDGP (dexamethasone, cisplatin, gemcitabine, pegaspargase);
   d. AspaMetDex (pegaspargase, methotrexate, dexamethasone);
   **Prior authorization may be required*
6. 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: 6 months

C. 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 one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace, and CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, and CP.PMN.16 for Medicaid; 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 the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

II. Continued Therapy

A. All Indications in Section I (must meet all)**:**
1. Currently receiving medication via Centene benefit, or documentation supports that member is currently receiving Oncaspar or Asparlas 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 Asparlas, age 1 month to ≤ 21 years;

4. If request is for a dose increase, request meets one of the following (a, b, or c):*
   a. Oncaspar: New dose does not exceed 2,500 IU/m^2 every 14 days (age ≤ 21 years) or 2,000 IU/m^2 every 14 days (age > 21 years);
   b. Asparlas: New dose does not exceed 2,500 units/m^2 every 21 days;
   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: 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 one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace, and CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, and CP.PMN.16 for Medicaid; 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 the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.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 policies – CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid, or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation Key
ALL: acute lymphoblastic leukemia
FDA: Food and Drug Administration
NCCN: National Comprehensive Cancer Network

Appendix B: Therapeutic Alternatives
Not applicable

Appendix C: Contraindications/Boxed Warnings

- Contraindication(s):
  - History of serious allergic reactions to Oncaspar or to pegylated L-asparaginase therapy
  - History of serious thrombosis with prior L-asparaginase therapy
  - History of pancreatitis with prior L-asparaginase therapy
  - History of serious hemorrhagic events with prior L-asparaginase therapy
  - Severe hepatic impairment
- Boxed warning(s): none reported

V. Dosage and Administration

Drug Name	Indication	Dosing Regimen	Maximum Dose
Oncaspar (pegaspargase)	ALL	Age ≤ 21 years: 2,500 IU/m^2 IM or IV no more frequently than every 14 days Age > 21 years: 2,000 IU/m^2 IM or IV no more frequently than every 14 days	Age ≤ 21 years: 2,500 IU/m^2 every 14 days Age > 21 years: 2,000 IU/m^2 every 14 days
Asparlas (calaspargase pegol-mknl)	ALL	Age 1 month to 21 years: 2,500 units/m^2 IV no more frequently than every 21 days	2,500 units/m^2 every 21 days

VI. Product Availability

Drug Name	Availability
Oncaspar (pegaspargase)	Single-dose vial: 3,750 IU/5 mL solution
Asparlas (calaspargase pegol-mknl)	Single-dose vial: 3,750 units/5 mL solution

VII. References

1. Oncaspar Prescribing Information. Boston, MA: Servier Pharmaceuticals LLC; November 2021. Available at: http://www.oncaspar.com/. Accessed August 1, 2022.
2. Asparlas Prescribing Information. Boston, MA: Servier Pharmaceuticals LLC; December 2021. Available at: http://asparlas.com/. Accessed August 1, 2022.
3. National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at: http://www.nccn.org/professionals/drug_compendium. Accessed August 1, 2022.
4. National Comprehensive Cancer Network. Acute Lymphoblastic Leukemia Version 1.2022. Available at www.nccn.org. Accessed August 1, 2022.
5. National Comprehensive Cancer Network. Pediatric Acute Lymphoblastic Leukemia Version 1.2022. Available at: https://www.nccn.org/professionals/physician_gls/pdf/ped_all.pdf. Accessed August 1, 2022.
6. National Comprehensive Cancer Network. T-Cell Lymphomas Version 2.2022. Available at www.nccn.org. Accessed August 1, 2022.

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
J9118	Injection, calaspargase pegol-mknl (Asparlas), 10 units
J9266	Injection, pegaspargase (Oncaspar), per single dose vial

Reviews, Revisions, and Approvals	Date	Approval Date
4Q 2018 annual review: added Commercial and HIM lines of business; added age requirements; summarized NCCN and FDA-approved uses for improved clarity; added specialist involvement in care; added off-label use for Ph+ ALL following tyrosine kinase inhibitor therapy; references reviewed and updated.	07.12.18	11.18
4Q 2019 annual review: ALL age limit/drug trial removed per PI; off-label T-cell age limit added in absence of NCCN pediatric guidance; FDA/NCCN dosing limitation added; references reviewed and updated.	08.27.19	11.19
RT4: added Asparlas to policy; updated HCPCS codes.	11.13.19	
4Q 2020 annual review: extranasal and aggressive NK/T-cell subtypes and DDGP regimen added to NK/T-cell off-label criteria set - limited to Oncaspar per NCCN; references reviewed and updated.	08.11.20	11.20
4Q 2021 annual review: for ALL, clarified that age ≤ 21 years for Asparlas and added requirement that the requested agent is prescribed as part of a multi-agent chemotherapeutic regimen per FDA label and NCCN; for T-cell lymphoma, revised to include only nasal type extranodal NK/T-cell lymphoma (removed extranasal type and aggressive NK cell leukemia) and added hepatosplenic T-cell lymphoma per NCCN; added 12 month initial approval duration for Legacy WellCare (WCG.CP.PHAR.353 retired); references to HIM.PHAR.21 revised to HIM.PA.154; references reviewed and updated.	06.28.21	11.21
4Q 2022 annual review: no significant changes; approval duration for Legacy Wellcare consolidated to 6 months for initial approval criteria; clarified age 1 month to ≤ 21 years for Asparlas per PI; references reviewed and updated. Template changes applied to other diagnoses/indications.	08.01.22	11.22

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. The Health Plan 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. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

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 Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. 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. The Health Plan 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 the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note:
For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.