STATE OF IOWA DEPARTMENT OF
Health AND Human
SERVICES

Rylaze [asparaginase erwinia chrysanthemi (recombinant)-rywn]
PAM-043

Iowa Medicaid Program:	Prior Authorization	**Effective Date:**	01/01/2022
Revision Number:	3	**Last Rev Date:**	07/19/2024
Reviewed By:	Medicaid Medical Director	**Next Rev Date:**	07/18/2025
Approved By:	Medicaid Clinical Advisory Committee	**Approved Date:**	07/15/2022

Overview

Medication: [1]	asparaginase erwinia chrysanthemi (recombinant)-rywn
Brand Name:	Rylaze®
Pharmacologic Category:	Antineoplastic agent; asparaginase specific enzyme
FDA-Approved Indication(s):	Indicated as a component of a multi-agent chemotherapeutic regimen for the treatment of acute lymphoblastic leukemia (ALL) and lymphoblastic lymphoma (LBL) in adult and pediatric patients 1 month or older who have developed hypersensitivity to E. coli-derived asparaginase.
How Supplied:	One carton of Rylaze® contains 3 single-dose vials (10 mg/0.5 mL per vial)
Dosage and Administration:	Two regimens that can be used to replace a long-acting asparaginase product: 1. Administer every 48 hours ▪ 25 mg/m^2 administered intramuscularly every 48 hours 2. Administer on a Monday-Wednesday-Friday schedule ▪ Monday morning: 25 mg/m^2 administered intramuscularly ▪ Wednesday morning: 25 mg/m^2 administered intramuscularly ▪ Friday afternoon: 50 mg/m^2 administered intramuscularly (53 to 58 hours after the Wednesday morning dose) See the full prescribing information for the long-acting asparaginase product to determine the duration of administration of Rylaze® as replacement therapy.
Benefit Category:	Medical

Descriptive Narrative

Asparaginase specific enzymes are enzymes that work by depleting blood plasma levels of asparagine. Normal cells create more asparagine; however, some leukemic cells are not able to synthesize this amino acid and subsequently die. Asparaginase specific enzymes are primarily used to treat acute lymphoblastic leukemia (ALL).

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 one (1) month or older who have developed hypersensitivity to E. coli-derived asparaginase.

Guidelines

As new and emerging therapies are rapidly coming to market, oncology treatment recommendations and guidelines are constantly changing. To keep up with these changes, the National Comprehensive Cancer Network (NCCN) publishes guidelines which are developed and updated by 60 individual panels, comprising over 1,660 clinicians and oncology researchers from the 31 NCCN Member Institutions.[2]

The NCCN Clinical practice Guidelines in Oncology (NCCN Guidelines®) are a work in progress that may be refined as often as new significant data becomes available. To view the most recent and complete version of the guidelines, go online to NCCN.org. NCCN makes no warranties of any kind whatsoever regarding their content, use or application and disclaims any responsibility for their application or use in any way.

The information referenced at the time of this policy writing/revision is from:

- NCCN Guidelines® for Acute Lymphoblastic Leukemia (Version 4.2023 – February 5, 2024)[3]

NCCN Guidelines® recommendation(s) for asparaginase erwinia chrysanthemi (recombinant)-rywn (Rylaze®)
(1) Acute Lymphoblastic Leukemia (ALL) or Lymphoblastic Lymphoma (LBL) A. Supportive care – asparaginase toxicity management i. Asparaginase erwinia chrysanthemi (recombinant)-rywn: Category 2A second-line agent in patients who have developed a systemic allergic reaction or anaphylaxis due to pegaspargase (PEG) hypersensitivity

NCCN Categories of Evidence and Consensus (all recommendations are category 2A unless otherwise indicated)	
Category 1	Based upon high-level evidence, there is uniform NCCN consensus that the intervention is appropriate.
Category 2A	Based upon lower-level evidence, there is uniform NCCN consensus that the intervention is appropriate.
Category 2B	Based upon lower-level evidence, there is NCCN consensus that the intervention is appropriate.
Category 3	Based upon any level of evidence, there is major NCCN disagreement that the intervention is appropriate.

NCCN Categories of Preference (all recommendations are considered appropriate)	
Preferred intervention	Interventions that are based on superior efficacy, safety, and evidence; and, when appropriate, affordability.
Other recommended intervention	Other interventions that may be somewhat less efficacious, more toxic, or based on less mature data; or significantly less affordable for similar outcomes.
Useful in certain circumstances	Other interventions that may be used for select patient populations (defined with recommendation).

Criteria

Prior authorization is required.

Rylaze® is considered medically necessary when **ALL** of the following are met:

1. Diagnosis of acute lymphoblastic leukemia (ALL) or lymphoblastic lymphoma; **AND**
2. Prescribed as a component of a multi-agent chemotherapeutic regimen; **AND**
3. Member has developed hypersensitivity to an *E. Coli* derived asparaginase product; **AND**
4. Prescribed by, or in consultation with, an oncologist; **AND**
5. Request meets one of the following (a, b, or c):
    a. Dose is administered every 48 hours and does not exceed 25 mg/m^2; **OR**
    b. Dose is administered every Monday, Wednesday, and Friday, and:
        i. Monday morning dose does not exceed 25 mg/m^2; **AND**
        ii. Wednesday morning dose does not exceed 25 mg/m^2; **AND**
        iii. Friday afternoon dose does not exceed 50 mg/m^2; **OR**
    c. Regimen is supported by clinical practice guidelines (i.e., must be recommended in NCCN Guidelines®). Supporting clinical documentation must be provided with any request for which regimen prescribed does not align with FDA-approved labeling.

Rylaze® is considered medically necessary for continuation of therapy when **ALL** of the following are met:

1. Member is currently receiving medication through the Iowa Medicaid benefit or has previously met initial approval criteria; **AND**
2. Documentation of positive clinical response to therapy, as demonstrated by tumor response or lack of disease progression, and an acceptable toxicity profile; **AND**
3. Prescribed by, or in consultation with, an oncologist; **AND**
4. Request meets one of the following (a, b, or c):
    a. Dose is administered every 48 hours and does not exceed 25 mg/m^2; **OR**
    b. Dose is administered every Monday, Wednesday, and Friday, and:
        i. Monday morning dose does not exceed 25 mg/m^2; **AND**
        ii. Wednesday morning dose does not exceed 25 mg/m^2; **AND**
        iii. Friday afternoon dose does not exceed 50 mg/m^2; **OR**
    c. Regimen is supported by clinical practice guidelines (i.e., must be recommended in NCCN Guidelines®). Supporting clinical documentation must be provided with any request for which regimen prescribed does not align with FDA-approved labeling.

Approval Duration and Quantity Limits

	Initial Authorization	Subsequent Authorization(s)
Approval Duration	3 months	6 months
Quantity Limits	Dose may not exceed: A) 25 mg/m^2 every 48 hours (when following the 48-hour dosing regimen) OR B) 25 mg/m^2 on Mon-Wed and 50 mg/m^2 on Friday (when following the Mon-Wed-Fri dosing regimen)	

Coding and Product Information

The following list(s) of codes and product information are provided for reference purposes only and may not be all inclusive. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment, nor does the exclusion of a code imply that its association to the HCPCS code is inappropriate.

HCPCS	Description
J9021	Injection, asparaginase, recombinant, (rylaze), 0.1 mg

ICD-10	Description
C83.50 – C83.59	Lymphoblastic (diffuse) lymphoma
C91.00 – C91.02	Acute lymphoblastic leukemia (ALL)

NDC (Strength)	Labeler	Dosage	Pkg Size	Pkg Qty	Units/ Pkg
68727-0900-01 (single-dose vial, 10 mg/0.5 mL)	Jazz Pharmaceuticals, Inc. (68727)	0.1 mg	1	EA	100
68727-0900-03 (carton of 3 single-dose vials)	Jazz Pharmaceuticals, Inc. (68727)	0.1 mg	1	EA	300

Compliance

1. Should conflict exist between this policy and applicable statute, the applicable statute shall supersede.
2. Federal and State law, as well as contract language, including definitions and specific contract provisions or exclusions, take precedence over medical policy and must be considered first in determining eligibility for coverage.
3. Medical technology is constantly evolving, and Iowa Medicaid reserves the right to review and update medical policy on an annual or as-needed basis.

Medical necessity guidelines have been developed for determining coverage for member benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. Medical necessity guidelines are developed for selected physician administered medications found to be safe and proven to be effective in a limited, defined population or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in the service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. Criteria are revised and updated annually, or more frequently if new evidence becomes available that suggests needed revisions.

References

[1] Rylaze prescribing information (04/2024). Jazz Pharmaceuticals, Inc.: Palo Alto, CA. Available online at www.rylaze.com. Accessed June 1, 2024.

[2] National Comprehensive Cancer Network (NCCN). Development and Update of Guidelines. Available online at www.nccn.org. Accessed October 11, 2023.

[3] Referenced from the NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®) for Acute Lymphoblastic Leukemia v.4.2023 – February 5, 2024. Accessed June 8, 2024. The NCCN Guidelines are a work in progress that may be refined as often as new significant data becomes available. To view the most recent and complete version of the guideline, go online to NCCN.org.

Development of utilization management criteria may also involve research into other state Medicaid programs, other payer policies, consultation with experts and review by the Medicaid Clinical Advisory Committee (CAC). These sources may not be referenced individually unless they are specifically published and are otherwise applicable to the criteria at issue.

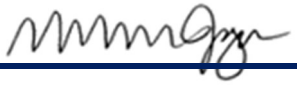
Criteria Change History

Change Date	Changed By	Description of Change	Version
[mm/dd/yyyy]			
Signature			

Change Date	Changed By	Description of Change	Version
[mm/dd/yyyy]			
Signature			

Change Date	Changed By	Description of Change	Version
07/19/2024	CAC	Annual review. Added dosing information into criteria. Reviewed NCCN Guidelines (no changes) and updated references.	3
Signature William (Bill) Jagiello, DO			

Change Date	Changed By	Description of Change	Version
07/21/2023	CAC	Annual review. Alternative dosing regimen approved by FDA, added to Overview section and updated in Quantity Limits.	2
Signature William (Bill) Jagiello, DO			

Change Date	Changed By	Description of Change	Version
07/15/2022	CAC	Criteria implementation.	1
Signature William (Bill) Jagiello, DO			

CAC = Medicaid Clinical Advisory Committee