Asparaginase *Erwinia chrysanthemi* (Erwinaze®)

Place of Service

Office Administration
Outpatient Facility Infusion Administration
Infusion Center Administration

HCPCS: J9019 per 1,000 IU

Condition(s) listed in policy (*see criteria for details*)

- Acute lymphoblastic leukemia (ALL)
- T-cell lymphoma

AHFS therapeutic class: Antineoplastic

Mechanism of action: Erwinaze is the enzyme asparaginase derived from *Erwinia chrysanthemi*. The antineoplastic mechanism of action of asparaginase is proposed to be based on selective killing of leukemic cells caused by depletion of plasma asparagines**.**

(1) Special Instructions and Pertinent Information

Covered under the Medical Benefit, please submit clinical information for prior authorization review via fax.

(2) Prior Authorization/Medical Review is required for the following condition(s)

All requests for Erwinaze® (asparaginase *Erwinia chrysanthemi*) must be sent for clinical review and receive authorization prior to drug administration or claim payment.

Acute lymphoblastic leukemia (ALL)

1. Patient has developed hypersensitivity to E. coli-derived asparaginase (e.g., Asparlas, Oncaspar), **AND**
2. Being used as a component of a multi-agent chemotherapeutic regimen

Covered Doses
Up to 25,000 IU/m^2 IM up to three times a week

Coverage Period
Cover for the duration of multi-agent chemotherapeutic regimen

ICD-10:
C83.50-C83.59, C91.00-C91.02

T-cell lymphoma

1. Patient has developed hypersensitivity to E. coli-derived asparaginase (e.g., Oncaspar), **AND**
2. Being used as a component of a multi-agent chemotherapeutic regimen

Covered Doses

Up to 25,000 IU/m^2 IM up to three times a week

Coverage Period
Cover for the duration of multi-agent chemotherapeutic regimen

ICD-10:
C84.90-C84.99, C84.Z0, C84.Z1, C84.Z2, C84.Z3, C84.Z4, C84.Z5, C84.Z6, C84.Z7, C84.Z8, C84.Z9, C86.0

(3) The following condition(s) DO NOT require Prior Authorization/Preservice

All requests for Erwinaze® (asparaginase *Erwinia chrysanthemi*) must be sent for clinical review and receive authorization prior to drug administration or claim payment.

(4) This Medication is NOT medically necessary for the following condition(s)

Coverage for a Non-FDA approved indication, requires that criteria outlined in Health and Safety Code § 1367.21, including objective evidence of efficacy and safety are met for the proposed indication.

Please refer to the Provider Manual and User Guide for more information.

(5) Additional Information

How supplied:

- 10,000 IU (single-use vial)

(6) References

- AHFS®. Available by subscription at http://www.lexi.com
- DrugDex®. Available by subscription at http://www.micromedexsolutions.com/home/dispatch
- Erwinaze® (asparaginase *Erwinia chrysanthemi*) [Prescribing information]. Palo Alto, CA: Jazz Pharmaceuticals, 3/2019.
- National comprehensive cancer network. Acute lymphoblastic leukemia (Version 4.2021). Available at: www.nccn.org
- National comprehensive cancer network. Pediatric acute lymphoblastic leukemia (Version 2.2021). Available at: www.nccn.org.
- National Comprehensive Cancer Network. T-Cell Lymphomas (Version 2.2022). Available at: www.nccn.org.

(7) Policy Update

Date of last review: 2Q2022
Date of next review: 2Q2023
Changes from previous policy version:

- New indication in Section (2): Added coverage for T-cell lymphoma

  Rationale: NCCN category 2A support

BSC Drug Coverage Criteria to Determine Medical Necessity
Reviewed by P&T Committee