Clinical Policy Title:	asparaginase *erwinia chrysanthemi*
Policy Number:	RxA.377
Drug(s) Applied:	Erwinaze®
Original Policy Date:	03/06/2020
Last Review Date:	08/28/2024
Line of Business Policy Applies to:	All lines of business (except Medicare)

Criteria

I. Initial Approval Criteria

A. Acute lymphoblastic leukemia (ALL) (must meet all)**:**

1. Diagnosis of ALL;
2. Request meets one of the following (a or b):
   a. Member has developed hypersensitivity to an *E. coli* derived asparaginase product pegaspargase (Oncaspar®);
   b. Used as a component of multi-agent chemotherapeutic regimen for the induction therapy in adults ≥ 65 years of age or with substantial comorbidities.

Approval duration

All Lines of Business (except Medicare): 3 months

II. Continued Therapy Approval

A. Acute lymphoblastic leukemia (ALL) (must meet all)**:**

1. Auto-approval based on lookback functionality within the past 120 days as a proxy for member responding positively to therapy.

Approval duration

All Lines of Business (except Medicare): 12 months

References

1. National Comprehensive Cancer Network Guidelines. Acute Lymphoblastic Leukemia. Version 2.2024. Available at: https://www.nccn.org/professionals/physician_gls/pdf/all.pdf . Accessed August 28, 2024.

Review/Revision History	Review/Revised Date	P&T Approval Date
Policy established.	01/2020	03/06/2020
Policy was reviewed: 1. Policy description table updated 2. Continuation therapy criteria II.A.1. rephrased to “Member is currently receiving medication that has been authorized by RxAdvance”. 3. Initial therapy and continued therapy approval duration added for	07/23/2020	09/14/2020

commercial, medicaid and HIM separately 4. References were updated		
Policy was reviewed: 1. Initial Approval Criteria I.A.2.b was updated to include “for the induction therapy in adults ≥ 65 years of age or with substantial comorbidities” 2. Initial Approval Criteria I.A.3 was consolidated with I.A.2.b to form new criteria I.A.2, “Request meets one of the following (a or b):”. 3. Initial Approval Criteria I.A was updated to include the disclaimer “*Prescribed regimen must be FDA-approved or recommended by NCCN.” 4. Initial Approval Criteria and Continued Therapy Approval Criteria were updated to remove HIM approval duration. 5. References were reviewed and updated.	06/01/2021	09/14/2021
Policy was reviewed: 1. References were reviewed and updated	3/23/2022	07/18/2022
Policy was reviewed: 1. References were reviewed and updated.	04/17/2023	07/13/2023
Policy was reviewed.	10/19/2023	10/19/2023
Policy was reviewed: 1. Removed prescriber restrictions. 2. Removed dose restrictions. 3. Updated Continued therapy approval with auto-approval based on lookback functionality within the past 120 days. 4. Removed reauthorization requirement for positive response to therapy. 5. Updated approval duration verbiage. 6. References were reviewed and updated.	08/28/2024	9/13/2024