SPECIALTY GUIDELINE MANAGEMENT

ERWINAZE (asparaginase *Erwinia chrysanthemi*)

POLICY

I. INDICATIONS

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

A. FDA-Approved Indications
Erwinaze is indicated as a component of a multi-agent chemotherapeutic regimen for the treatment of patients with acute lymphoblastic leukemia (ALL) who have developed hypersensitivity to *E. coli*-derived asparaginase.

B. Compendial Uses
Lymphoblastic lymphoma (managed in the same manner as ALL)

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

Authorization of 12 months may be granted for the treatment of acute lymphoblastic leukemia or lymphoblastic lymphoma when all of the following criteria are met:
A. Erwinaze will be used in conjunction with multi-agent chemotherapy.
B. The member has previously received and developed hypersensitivity to an *E. coli*-derived asparaginase (eg, Oncaspar).

III. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must meet all initial authorization criteria.

IV. REFERENCES

1. Erwinaze [package insert]. Palo Alto, CA: Jazz Pharmaceuticals, Inc.; March 2016.
2. National Comprehensive Cancer Network. NCCN Clinical Practice Guidelines in Oncology: Acute Lymphoblastic Leukemia. Version 1.2017. http://www.nccn.org/professionals/physician_gls/pdf/all.pdf. Accessed August 29, 2017.
3. National Comprehensive Cancer Network. The NCCN Drugs & Biologics Compendium. http://www.nccn.org. Accessed August 23, 2017.