POLICY NUMBER UM ONC_1352	SUBJECT Asparlas™ (calaspargase pegol-mknl)		DEPT/PROGRAM UM Dept	PAGE 1 OF 2
DATES COMMITTEE REVIEWED 02/13/19, 12/11/19, 02/12/20	APPROVAL DATE February 12, 2020	EFFECTIVE DATE March 01, 2020	COMMITTEE APPROVAL DATES (latest version listed last) 02/13/19, 12/11/19, 02/12/20	
PRIMARY BUSINESS OWNER: UM APPROVED BY: Dr. Andrew Hertler		COMMITTEE/BOARD APPROVAL Utilization Management Committee		
URAC STANDARDS HUM 1		NCQA STANDARDS UM 2	ADDITIONAL AREAS OF IMPACT	
CMS REQUIREMENTS	STATE/FEDERAL REQUIREMENTS		APPLICABLE LINES OF BUSINESS Commercial, Exchange, Medicaid	

I. PURPOSE

To define and describe the accepted indications for Asparlas (calaspargase pegol-mknl) usage in the treatment of cancer, including FDA approved indications, and off-label indications.

New Century is responsible for processing all medication requests from network ordering providers. Medications not authorized by New Century may be deemed as not approvable and therefore not reimbursable.

The use of this drug must be supported by one of the following: FDA approved product labeling, CMS-approved compendia, National Comprehensive Cancer Network (NCCN), American Society of Clinical Oncology (ASCO) clinical guidelines, or peer-reviewed literature that meets the requirements of the CMS Medicare Benefit Policy Manual Chapter 15.

II. INDICATIONS FOR USE/INCLUSION CRITERIA

1. **PREFERRED MEDICATION GUIDANCE FOR INITIAL REQUEST:**
    a. When health plan Medicaid coverage provisions- including any applicable PDLs (Preferred Drug Lists)- conflict with the coverage provisions in this drug policy, health plan Medicaid coverage provisions take precedence per the **Preferred Drug Guidelines OR**
    b. When health plan Exchange coverage provisions- including any applicable PDLs (Preferred Drug Lists)- conflict with the coverage provisions in this drug policy, health plan Exchange coverage provisions take precedence per the **Preferred Drug Guidelines OR**
    c. For Health Plans that utilize NCH UM Oncology Clinical Policies as the initial clinical criteria, the **Preferred Drug Guidelines shall follow NCH L1 Pathways** when applicable, otherwise shall follow NCH drug policies: http://pathways.newcenturyhealth.com **AND**
    d. Continuation requests of previously approved non-preferred medication are not subject to this provision **AND**
    e. When available, generic alternatives are preferred over brand-name drugs.
2. **Acute Lymphoblastic Leukemia (ALL)**
    a. The member has a diagnosis of ALL **AND**
    b. Unless contraindicated or not tolerated, Oncaspar is preferred over Asparlas for use in in combination with induction or consolidation chemotherapy.

III. EXCLUSION CRITERIA

1. Asparlas (calaspargase pegol-mknl) is being used after disease progression with the same regimen or Oncaspar (pegasparagase).

2. Serious hypersensitivity reactions, pancreatis, or hemorrhagic events, serious thrombosis, or Severe hepatic impairment to asparaginase therapy.
3. Dosing exceeds single dose limit of Asparlas (calaspargase pegol-mknl) 2,500 units/m^2.
4. Indications not supported by CMS recognized compendia or acceptable peer reviewed literature.

IV. MEDICATION MANAGEMENT

Please refer to the FDA label/package insert for details regarding these topics.

V. APPROVAL AUTHORITY

1. Review – Utilization Management Department
2. Final Approval – Utilization Management Committee

VI. ATTACHMENTS

None

VII. REFERENCES

1. Asparlas PI prescribing information. Servier Pharmaceuticals LLC. Boston, MA 2019.
2. Clinical Pharmacology Elsevier Gold Standard. 2020.
3. Micromedex® Healthcare Series: Thomson Micromedex, Greenwood Village, Co. 2020.
4. National Comprehensive Cancer Network. Cancer Guidelines and Drugs and Biologics Compendium. 2020.
5. AHFS Drug Information. American Society of Health-Systems Pharmacists or Wolters Kluwer Lexi-Drugs. Bethesda, MD. 2020.