Drug Policy:

Oncaspar™ (pegaspargase)

POLICY NUMBER UM ONC_1063	**SUBJECT** Oncaspar™ (pegaspargase)		**DEPT/PROGRAM** UM Dept	**PAGE 1 OF 3**
DATES COMMITTEE REVIEWED 02/20/11, 12/07/11, 09/13/13, 10/02/14, 11/12/14, 12/18/15, 12/21/16, 10/11/17, 09/21/18, 08/14/19, 12/11/19, 06/10/20, 06/09/21, 08/11/21, 10/13/21	**APPROVAL DATE** October 13, 2021	**EFFECTIVE DATE** October 29, 2021	**COMMITTEE APPROVAL DATES** 02/20/11, 12/07/11, 09/13/13, 10/02/14, 11/12/14, 12/18/15, 12/21/16, 10/11/17, 09/21/18, 08/14/19, 12/11/19, 06/10/20, 06/09/21, 0/8/11/21, 10/13/21	
PRIMARY BUSINESS OWNER: UM		**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 Oncaspar (pegaspargase) usage in the treatment of cancer, including FDA approved indications, and off-label indications.

New Century Health (NCH) is responsible for processing all medication requests from network ordering providers. Medications not authorized by NCH 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

A. PREFERRED MEDICATION GUIDANCE FOR INITIAL REQUEST:

1. 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
2. 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

3. 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 AND
4. Continuation requests of previously approved, non-preferred medication are not subject to this provision AND
5. When applicable, generic alternatives are preferred over brand-name drugs.

B. Acute Lymphocytic Leukemia (ALL) including T-Cell Lymphoma/Leukemia

1. NOTE: Per NCH Policy & NCH Pathway, Asparlas (calaspargase pegol-mknl) is preferred over Oncaspar (pegasparagase) for use in ALL as a part of anti-leukemia therapy. Rationale: AALL07P4 clinical trial results demonstrated no substantial difference in event free survival using Asparlas in comparison to patients treated with pegaspargase in the treatment of ALL. Please refer to *UM ONC_1352 Asparlas (calaspargase pegol-mknl) policy.*
2. Oncaspar (pegasparase) use is supported as part of a multi-agent chemotherapy regimen for all sub-types of Acute Lymphocytic Leukemia (ALL), for induction/consolidation therapy, and for therapy of relapsed/refractory disease.

III. EXCLUSION CRITERIA

A. Oncaspar (pegaspargase) is being used as a single agent and not part of a multi-agent chemotherapy.

B. Dosing exceeds single dose limit of Oncaspar (pegaspargase) 2,500 IU/m^2 (maximum 3,750 units per dose).

C. Indications not supported by CMS recognized compendia or acceptable peer reviewed literature.

IV. MEDICATION MANAGEMENT

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

V. APPROVAL AUTHORITY

A. Review – Utilization Management Department

B. Final Approval – Utilization Management Committee

VI. ATTACHMENTS

A. None

VII. REFERENCES

A. Schore RJ, Devidas M, Bleyer A, Reaman GH, Winick N, Loh ML, Raetz EA, Carroll WL, Hunger SP, Angiolillo AL. Plasma asparaginase activity and asparagine depletion in acute lymphoblastic leukemia patients treated with pegaspargase on Children's Oncology Group AALL07P4(.). Leuk Lymphoma. 2019 Jul;60(7):1740-1748.

B. Oncaspar prescribing information. Servier Pharmaceuticals Boston, MA 2020.

C. Clinical Pharmacology Elsevier Gold Standard 2021.

D. Micromedex® Healthcare Series: Thomson Micromedex, Greenwood Village, CO 2021.

New Century Health

E. National Comprehensive Cancer Network. Cancer Guidelines and Drugs and Biologics Compendium 2021.

F. AHFS Drug Information. American Society of Health-Systems Pharmacists or Wolters Kluwer Lexi-Drugs. Bethesda, MD 2021.