PreferredOne®

PRIOR AUTHORIZATION POLICY

POLICY: Oncology (Injectable) – Oncaspar Prior Authorization Policy
- Oncaspar® (pegaspargase injection for intramuscular or intravenous use – Servier)

REVIEW DATE: 06/02/2021

OVERVIEW

Oncaspar a conjugate of *Escherichia coli*-derived L-asparaginase and monomethoxypolyethylene glycol (mPEG), is indicated as a component of a multi-agent chemotherapy regimen for **acute lymphoblastic leukemia** (ALL), for first-line treatment of pediatric and adult patients, and treatment of pediatric and adult ALL patients with hypersensitivity to native forms of L-asparaginase.[1]

Guidelines

Oncaspar is addressed in National Comprehensive Cancer Network (NCCN) guidelines:

- **ALL:** The NCCN guidelines for **ALL** (version 1.2021 – April 6, 2021) and for **Pediatric ALL** (version 2.2021 – October 22, 2020) recommend pegaspargase as a component of a multi-agent chemotherapeutic regimen for induction/consolidation therapy for ALL, for induction therapy in Philadelphia chromosome-negative ALL in patients ≥ 65 years of age, for relapsed/refractory Philadelphia chromosome-negative ALL, and relapsed/refractory Philadelphia chromosome-positive ALL.[2,3,5]
- **T-cell lymphomas:** The NCCN guidelines (version 1.2021 – October 5, 2020) recommend pegaspargase as a component of therapy for extranodal NK/T-cell lymphoma, nasal type and as an alternative induction regimen if no response or progressive disease after primary treatment for hepatosplenic T-cell lymphoma.[3,4]

POLICY STATEMENT

Prior Authorization is recommended for prescription benefit coverage of Oncaspar. All approvals are provided for the duration noted below. Because of the specialized skills required for evaluation and diagnosis of patients treated with Oncaspar as well as the monitoring required for adverse events and long-term efficacy, approval requires Oncaspar to be prescribed by or in consultation with a physician who specializes in the condition being treated.

Automation: None.

RECOMMENDED AUTHORIZATION CRITERIA

Coverage of Oncaspar is recommended in those who meet the following criteria:

FDA-Approved Indications

1. **Acute Lymphoblastic Leukemia.** Approve for 1 year if Oncaspar is prescribed by or consultation with an oncologist.

Other Uses with Supportive Evidence

2. **Extranodal NK/T-cell Lymphoma, Nasal Type**. Approve for 1 year if Oncaspar is prescribed by or in consultation with an oncologist.

3. **Hepatosplenic T-cell Lymphoma**. Approve for 1 year if the patient meets the following criteria (A and B):
   A) Patient had no response or progressive disease after primary treatment; AND
   B) Oncaspar is prescribed by or in consultation with an oncologist.

CONDITIONS NOT RECOMMENDED FOR APPROVAL

Coverage of Oncaspar is not recommended in the following situations:

1. Coverage is not recommended for circumstances not listed in the Recommended Authorization Criteria. Criteria will be updated as new published data are available.

REFERENCES

1. Oncaspar® injection for intramuscular and intravenous use [prescribing information]. Boston, MA: Servier Pharmaceutics; June 2020.
2. The NCCN Acute Lymphoblastic Leukemia Clinical Practice Guidelines in Oncology (Version 1.2021 – April 6, 2021). © 2021 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed May 11, 2021.
3. The NCCN Drugs and Biologics Compendium. © 2021 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed on May 11, 2021. Search term: pegaspargase.
4. The NCCN T-Cell Lymphomas Clinical Practice Guidelines in Oncology (Version 1.2021 – October 5, 2020). © 2020 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed May 11, 2021.
5. The NCCN Pediatric Acute Lymphoblastic Leukemia Clinical Practice Guidelines in Oncology (Version 2.2021 – October 22, 2020). © 2020 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed May 11, 2021.

HISTORY

Type of Revision	Summary of Changes	Review Date
Annual Revision	**Extranodal NK/T-cell Lymphoma, Nasal Type:** Removed "Oncaspar is used for one of the following (i, ii, or iii)" criteria. Added criteria for Hepatosplenic Gamma-Delta T-cell Lymphoma.	06/03/2020
Annual Revision	**Hepatosplenic T-cell Lymphoma:** The qualifier of "Gamma-Delta: was removed from the condition of approval.	06/02/2021

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Provides free aids and services to people with disabilities to communicate effectively with us, such as:

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Grievance Specialist
PreferredOne Community Health Plan
PO Box 59052
Minneapolis, MN 55459-0052
Phone: 1.800.940.5049 (TTY: 763.847.4013)
Fax: 763.847.4010
customerservice@preferredone.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, a Grievance Specialist is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

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U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

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