

SPECIALTY GUIDELINE MANAGEMENT

ONCASPAR (pegaspargase)

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

Acute lymphoblastic leukemia (ALL):

1. Oncaspar is indicated as a component of a multi-agent chemotherapeutic regimen for the first line treatment of pediatric and adult patients with ALL.
2. Oncaspar is indicated as a component of a multi-agent chemotherapeutic regimen for the treatment of pediatric and adult patients with ALL and hypersensitivity to native forms of L-asparaginase.

B. Compendial Uses

1. Extranodal natural killer/T-cell lymphoma, nasal type: as a component of multi-agent chemotherapeutic regimen
2. Lymphoblastic lymphoma (managed in the same manner as ALL)
3. Acute lymphoblastic leukemia (ALL) as a component of multi-agent chemotherapeutic regimen or central nervous system directed therapy as systemic therapy (IV/IM route)
4. Pediatric acute lymphoblastic leukemia (ALL) as a component of a multi-agent chemotherapeutic regimen
5. Hepatosplenic T-cell lymphoma as additional therapy if no response or progressive disease after first-line therapy, as a component of a multi-agent chemotherapeutic regimen

All other indications are considered experimental/investigational and not medically necessary.

II. CRITERIA FOR INITIAL APPROVAL

A. **Acute Lymphoblastic Leukemia (ALL) and Lymphoblastic Lymphoma (LL)**

Authorization of 12 months may be granted for the treatment of ALL or LL when the requested medication is used in conjunction with multi-agent chemotherapy or as central nervous system directed therapy as systemic therapy.

B. **Extranodal Natural Killer/T-cell Lymphoma, nasal type**

Authorization of 12 months may be granted for the treatment of extranodal natural killer/T-cell lymphoma, nasal type when the requested medication is used in conjunction with multi-agent chemotherapy.

C. **Hepatosplenic T-cell lymphoma**

Authorization of 12 months may be granted for the treatment of hepatosplenic T-cell lymphoma as subsequent therapy when the requested medication is used in conjunction with multi-agent chemotherapy.

III. CONTINUATION OF THERAPY

Reference number
2291-A

Authorization of 12 months may be granted for continued treatment in members requesting reauthorization for an indication listed in Section II when there is no evidence of unacceptable toxicity or disease progression while on the current regimen.

IV. REFERENCES

1. Oncaspar [package insert]. Boston, MA: Servier Pharmaceuticals LLC; June 2020.
2. The NCCN Drugs & Biologics Compendium® ©2021 National Comprehensive Cancer Network, Inc. <http://www.nccn.org>. Accessed May 27, 2021.