

**Rylaze (asparaginase erwinia chrystanthemi [recombinant]-rywn)
Effective 03/01/2022**

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|------------------------------|--|---------------------|---|
| Plan | <input checked="" type="checkbox"/> MassHealth <input type="checkbox"/> Commercial/Exchange | Program Type | <input checked="" type="checkbox"/> Prior Authorization <input type="checkbox"/> Quantity Limit <input type="checkbox"/> Step Therapy |
| Benefit | <input type="checkbox"/> Pharmacy Benefit <input checked="" type="checkbox"/> Medical Benefit (NLX) | | |
| Specialty Limitations | N/A | | |
| Contact Information | Specialty Medications | | |
| | All Plans | Phone: 866-814-5506 | Fax: 866-249-6155 |
| | Non-Specialty Medications | | |
| | MassHealth | Phone: 877-433-7643 | Fax: 866-255-7569 |
| | Commercial | Phone: 800-294-5979 | Fax: 888-836-0730 |
| | Exchange | Phone: 855-582-2022 | Fax: 855-245-2134 |
| | Medical Specialty Medications (NLX) | | |
| | All Plans | Phone: 844-345-2803 | Fax: 844-851-0882 |
| Exceptions | N/A | | |

Overview

Rylaze is indicated as a component of a multi-agent chemotherapeutic regimen for the treatment of acute lymphoblastic leukemia (ALL) and lymphoblastic lymphoma (LBL) in adult and pediatric patients 1 month or older who have developed hypersensitivity to E. coli-derived asparaginase.

Coverage Guidelines

Authorization may be granted for members new to AllWays Health Partners who are currently receiving treatment with Rylaze, excluding when the product is obtained as samples or via manufacturer’s patient assistance program

OR

Approval of Rylaze will be granted if the member meets all following criteria and documentation has been submitted:

1. The member has a diagnosis of acute lymphoblastic leukemia (ALL)
2. The prescriber is an oncologist or hematologist
3. The member has developed hypersensitivity to E.coli-derived asparaginase (e.g. pegasparagase)
4. Appropriate dosing

Continuation of Therapy

Reauthorizations requires physician documentation of continuation of therapy and positive response to therapy.

- Requests that exceed a total treatment duration of 36 weeks, documentation of clinical evidence supporting such an extended duration is required.

Limitations

1. Initial approvals will be granted for 36 weeks

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2. Reauthorizations will be granted for 12 months.

References

1. Rylaze [package insert]. Palo Alto, CA: Jazz Pharmaceuticals, Inc.; June 2021.

Review History

01/19/2022 - Reviewed and Created at Jan P&T. Effective 03/01/2022

Disclaimer

AllWays Health Partners complies with applicable federal civil rights laws and does not discriminate or exclude people on the basis of race, color, national origin, age, disability, or sex.