Cancer Care Ontario
Action Cancer Ontario | eClaims

Eligibility Form

Calaspargase Pegol (Inpatient) - Relapsed or Refractory Acute Lymphoblastic Leukemia, Lymphoblastic Lymphoma or Mixed/Biphenotypic Leukemia

(This form should be completed before the first dose is dispensed.)

1. Patient Profile

* Surname: _____

* Given Name: _____

* OHIN: _____ * Chart Number: _____

* Postal Code: _____

* Height (cm): _____ * Weight (kg): _____

* BSA (m^2): _____ * Gender: ○ Male ○ Female ○ Other

* Date of Birth: _____ _____ _____
Day Month Year

* Site:

* Attending Physician (MRP- Most Responsible Physician): _____

Requested Prior Approval ☐ Yes * Patient on Clinical Trial ○ Yes ○ No

Other (specify): _____

Specify Arm:
○ Standard of care arm ○ Experimental arm
○ Blinded / Unknown

Prior Approval Request

* Select the appropriate prior approval scenario:

- ○ 1-Unknown primary (submit pathology report and clinic note)
- ○ 2-Clinical document review (identify the patient history that needs to be reviewed against eligibility criteria in Additional Comments below)
- ○ 3-Regimen modification - schedule (complete questions a and b)
- ○ 4-Regimen modification - drug substitutions (complete questions a and c)
- ○ 5-Withholding a drug in combination therapy from start of treatment (complete questions d, e and f)
- ○ 6-Maintenance therapy delay (submit clinic note)
- ○ 7-Prior systemic therapy clinical trials (complete question g)
- ○ 8-Modification due to supply interruption/drug shortage
- ○ Other (specify)

.....

All relevant supporting documentation must be submitted at the time of prior approval. Documentation may include a pathology report, clinic note, and/or CT scans.

a. Co-morbidities / toxicity / justification:

.....

b. Intended regimen schedule: .....

c. Intended regimen: .....

d. Drug(s) to be held: .....

e. Rationale for holding drug(s): .....

f. Intention to introduce drug at a later date? ☐ Yes

g. Prior clinical trial identifier (e.g., NCT ID, trial name) and treatment description (e.g., arm, drug/regimen): .....

h. Anticipated date of first treatment: ....
Day Month Year

i. Additional comments:

2. Eligibility Criteria

Calaspargase pegol will be used as a component of multi-agent chemotherapeutic regimen for the treatment of patients with relapsed or refractory acute lymphoblastic leukemia (ALL), lymphoblastic lymphoma (LL), or mixed/biphenotypic leukemia (MPAL). ☐ Yes

3. Baseline Information

Diagnosis ○ B-ALL ○ T-ALL ○ B-LL ○ T-LL ○ MPAL

4. Funded Dose

Calaspargase pegol 2,500 units/m^2 intravenously (IV) every 21 days (as a component of a multi-agent chemotherapeutic regimen).

Treatment should continue until the development of a hypersensitivity reaction, silent inactivation, disease progression, or unacceptable high grade toxicity, whichever comes first.

5. Notes

1. Enrolment in this policy is for funding of calaspargase pegol doses administered in the inpatient setting only. For the funding of doses administered in the outpatient setting, a separate enrolment form must be submitted. See the policy *Calaspargase Pegol (Outpatient) - Relapsed or Refractory Acute Lymphoblastic Leukemia, Lymphoblastic Lymphoma or Mixed/Biphenotypic Leukemia*.

   Please ensure all claims are submitted through eClaims under the appropriate policies for inpatient and outpatient administered doses.

2. Calaspargase pegol will be reimbursed on a per vial basis.

6. FAQs

1. **My patient is currently on pegaspargase, can my patient switch to calaspargase pegol?**

   Switches to calaspargase pegol may be considered based on product availability. Please submit a prior authorization request noting that a switch is required due to the availability of pegaspargase. Patients should not be switched from pegaspargase to calaspargase pegol (or vice versa) for toxicity or silent inactivation.

Supporting Documents

None required at time of enrolment.

In the event of an audit or upon request, the following should be available to document eligibility:

- Clinic notes outlining patient's diagnosis and treatment history/response.

Signature of Attending Physician (MRP-Most Responsible Physician): _____

Day Month Year

Form 1070