

 WELLMED Doctors helping patients for more than 25 years	Effective Date: 01/21/2026	Revision Date(s): 02/18/22, 08/02/23, 07/31/24, 05/31/25, 07/25/25, 01/21/2026
Department: PHARMACY	MMC Review/ Approval Date(s): 08/04/23, 08/01/24, 01/21/2026	Page(s): 13
Policy Number: 048.003 Title: Coverage Determination Policy for Elitek (Rasburicase)		

Regions: **Texas** **Florida** **New Mexico**

Impacted Areas:	
<input checked="" type="checkbox"/> Network Management/Provider Services	<input checked="" type="checkbox"/> Utilization Management
<input type="checkbox"/> Member services	<input type="checkbox"/> Case management
<input type="checkbox"/> Quality Management	<input type="checkbox"/> Disease management
<input type="checkbox"/> Credentialing	<input checked="" type="checkbox"/> Claims
<input type="checkbox"/> IT	<input type="checkbox"/> Human resources
<input type="checkbox"/> Administration	<input type="checkbox"/> Finance
<input type="checkbox"/> Compliance/delegation	<input checked="" type="checkbox"/> Pharmacy
<input type="checkbox"/> ALL	

Approved by: Megan Ortiz, MD FACOG Senior Medical Director	Date:
---	--------------

Reviewed by: Sherien Zaid, Pharm.D Director, Clinical Pharmacy	Date:
---	--------------

Available LCD/NCD/LCA: None

Disclaimer:
 WellMed determines coverage decisions based on Medicare guidelines, including applicable statutes, regulations, NCDs (National Coverage Determinations), and LCDs (Local Coverage Determinations). In situations where no specific coverage criteria exist, or when NCDs/LCDs allow for clinical discretion, WellMed applies internal coverage policy. This internal coverage policy is informed by a structured review process that evaluates peer-reviewed scientific literature, broadly accepted clinical guidelines, and expert consensus to determine whether a service is reasonable and necessary for the diagnosis or treatment of an illness or to enhance patient function. Application of the internal coverage policy ensures alignment with evidence-based clinical standards when Medicare guidance is absent or insufficient to fully establish medical necessity.

Title: Coverage Determination Policy for Elitek (Rasburicase)

Table of Contents	Page	Coverage Policy Number: 048.003
Coverage Determination (Initial/New Requests)	3	Line of Business: Medicare Part B
Coverage Determination (Renewal/Continuation of Therapy Requests)	3	Policy Type: Prior Authorization
FDA Approved Dose and Indication	5	
General Background	6	
Clinical Evidence	8	
HCPCS Code	10	
Acronyms	11	
References	12	
Policy History/Revision Information	13	

Coverage Determination:

Initial/New Requests

ALL of the following criteria must be met in addition to any indication-specific criteria:

- Patient does not have Glucose-6-phosphate dehydrogenase (G6PD) deficiency
- Patient is currently receiving anti-cancer therapy
- Dosing is in accordance with the United States Food and Drug Administration approved labeling and established guidelines as outlined in the dosing table

WellMed Medical Management will cover **Elitek (Rasburicase)** as medically necessary for the following:

1. Prevention of tumor lysis syndrome (TLS) when **ONE** the following criteria are met:

A. Patient is at high risk for developing TLS as determined by **ONE** of the following:

- i. Acute lymphoblastic leukemia with $WBC \geq 100 \times 10^9 /L$ and/or serum LDH ≥ 2 -times ULN
- ii. Burkitt lymphoma/leukemia
- iii. Adult T cell leukemia/lymphoma, diffuse large B-cell, transformed, and mantle cell lymphomas with bulky disease and $LDH \geq 2 \times ULN$
- iv. Lymphoblastic lymphoma
- v. Acute myeloid leukemia with $WBC \geq 100 \times 10^9 /L$
- vi. Any cancer with renal involvement by tumor
- vii. Aggressive NHLs (including subtypes) with both bulky tumor mass (>10 cm in adults) and serum LDH $\geq ULN$
- viii. Chronic lymphocytic leukemia treated with venetoclax and lymph node ≥ 10 cm or lymph nodes ≥ 5 cm + absolute lymphocyte count $\geq 25 \times 10^9/L$ **and** elevated serum uric acid level

OR

B. Patient is at intermediate risk* for developing TLS with **ONE** of the following

- i. Renal dysfunction
- ii. Allergic to allopurinol
- iii. Uric acid, potassium, and/or phosphate $> ULN$

2. Treatment of TLS as determined by **ONE** of the following criteria:

A. Laboratory TLS as evidenced by **2 or more** of the following abnormalities within 3 days before and up to 7 days after initiation of treatment in a patient with cancer or undergoing treatment for cancer:

- i. Uric acid: ≥ 476 mmol/L (8 mg/dL) or higher or 25% increase from baseline
- ii. Potassium: ≥ 6 mmol/L (6 mEq/L) or higher or 25% increase from baseline
- iii. Phosphate (Adults): ≥ 1.45 mmol/L (4.5 mg/dL) or higher or 25% increase from baseline
- iv. Phosphate (Pediatrics): 2.1 mmol/L (6.5 mg/dL) or higher or 25% increase from baseline
- v. Corrected Calcium: ≤ 1.75 mmol/L (7 mg/dL) or ionized calcium ≤ 1.12 mmol/L (4.5 mg/dL) or less or 25% decrease from baseline

OR

B. Clinical TLS as defined by patients with laboratory TLS and at least ONE of the following findings:

- i. Creatinine: 1.5 or greater x ULN or higher (older than 12 years or age-adjusted)
- ii. Cardiac arrhythmia
- iii. Seizure
- iv. Any clinical setting of highly proliferative malignancy/highly treatment sensitive tumor expected to result in TLS following initiation of therapy

Note: Other clinical concerns will be decided on case-by-case basis

****Intermediate-Risk Disease: Stage I/II B-Cell Lymphomas and LDH <2X ULN***

FDA Approved Dose and Indication

Indication	Dose	Dose/Frequency Limitations
Prophylaxis or treatment (multidose weight-based)	0.2 mg/kg IV infusion over 30 minutes once daily for up to 5 days	Administration beyond 5 days or 1 course of treatment is not recommended (FDA dosage)
Prophylaxis of high-risk patients (single fixed-dose)	3 mg IV followed by careful monitoring	Repeat dose if necessary (guideline dosage)
Treatment of established tumor lysis syndrome (weight-based)	0.2 mg/kg/day IV as a 30 minute infusion	Duration determined by clinical response (guideline dosage)
Prophylaxis or treatment (single dose)	6 mg IV once or 0.15 mg/kg IV	May consider single doses of 3 or 4.5 mg if baseline uric acid level is less than 12 mg/dL, with monitoring and repeat dosing if required (off-label dosage)

Dose Adjustments:

- No dosage adjustment is needed for members with renal or hepatic impairment.

General Background

Black Box Warning:

Hypersensitivity reactions: Elitek can cause severe hypersensitivity reactions including anaphylaxis. Immediately and permanently discontinue Elitek therapy in patients who experience a serious hypersensitivity reaction.

Hemolysis: Do not administer Elitek to patients with glucose-6-phosphate dehydrogenase (G6PD) deficiency. Immediately and permanently discontinue Elitek in patients developing hemolysis. Screen patients at higher risk for G6PD deficiency (e.g., patients of African or Mediterranean ancestry) prior to starting Elitek.

Methemoglobinemia: Elitek can result in methemoglobinemia in some patients. Immediately and permanently discontinue Elitek in patients developing methemoglobinemia.

Interference with Uric Acid Measurements: Elitek enzymatically degrades uric acid in blood samples left at room temperature. Collect blood samples in pre-chilled tubes containing heparin and immediately immerse and maintain sample in an ice water bath. Assay plasma samples within 4 hours of collection.

Elitek (Rasburicase) is a recombinant urate oxidase produced by a genetically modified *Saccharomyces cerevisiae* strain. In humans, uric acid is the end product in the catabolic pathway of purines (most abundantly found in DNA), which is then primarily excreted by the kidneys. Urate oxidase catalyzes the oxidation of uric acid into the inactive and more soluble metabolite allantoin. Urate oxidase is found in most mammals but not humans. Rasburicase was first approved by the FDA in July 2002 for “the initial management of plasma uric acid levels in pediatric patients with leukemia, lymphoma, and solid tumor malignancies who are receiving anti-cancer therapy expected to result in tumor lysis and subsequent elevation of plasma uric acid.” The indication was expanded in October 2009 to include adult patients. Elitek was previously granted an orphan drug designation for “the treatment of malignancy-associated or chemotherapy-induced hyperuricemia” in October 2000.

Tumor lysis syndrome (TLS) consists of metabolic abnormalities caused by the rapid destruction of tumor cells and subsequent release of intracellular components. The syndrome is characterized by hyperuricemia and electrolyte abnormalities (i.e., hyperkalemia, hyperphosphatemia, hypocalcemia) and may lead to acute renal failure, arrhythmias, and/or death. Symptoms generally occur 12 to 72 hours after, but may occur prior to, initiation of chemotherapy. The malignancies most often associated with TLS include those with large tumor burden, rapid cell proliferation, and high sensitivity to chemotherapy. Large tumor burden for hematological malignancy is indicated by high white blood cell counts (WBCs) and elevated lactate dehydrogenase [i.e., >2X the upper limit of normal (ULN)]. Other risk factors include advanced age, preexisting renal dysfunction, and elevated baseline serum uric acid levels. Centerpiece of treatment includes vigorous hydration, management of hyperuricemia and frequent monitoring of electrolytes and aggressive correction (essential). Allopurinol or febuxostat are recommended for patients with low-risk or intermediate-risk disease. Rasburicase is recommended for intermediate-risk disease (if renal dysfunction and uric acid, potassium, and/or phosphate greater than ULN) or high-risk disease.

The NHLs that are classified as indolent (i.e., slow-growing or low grade) are marginal zone, nodal marginal zone B-cell, lymphoplasmacytic, peripheral T-cell, and follicular cell lymphomas; and Mycosis fungoides.

Serum uric acid should be measured at least 4 hours after the administration of rasburicase. It is recommended that uric acid be evaluated every 6 to 12 hours until levels are normalized.

TLS can also be classified into 2 separate categories such as laboratory or clinical (see referenced Table 1 below)¹⁶.

Clinical/Laboratory TLS

Table 1. Definitions of Laboratory and Clinical Tumor Lysis Syndrome.*		
Metabolic Abnormality	Criteria for Classification of Laboratory Tumor Lysis Syndrome	Criteria for Classification of Clinical Tumor Lysis Syndrome
Hyperuricemia	Uric acid >8.0 mg/dl (475.8 μmol/liter) in adults or above the upper limit of the normal range for age in children	
Hyperphosphatemia	Phosphorus >4.5 mg/dl (1.5 mmol/liter) in adults or >6.5 mg/dl (2.1 mmol/liter) in children	
Hyperkalemia	Potassium >6.0 mmol/liter	Cardiac dysrhythmia or sudden death probably or definitely caused by hyperkalemia
Hypocalcemia	Corrected calcium <7.0 mg/dl (1.75 mmol/liter) or ionized calcium <4.5 mg/dl (1.12 mmol/liter)†	Cardiac dysrhythmia, sudden death, seizure, neuromuscular irritability (tetany, paresthasias, muscle twitching, carpopedal spasm, Trousseau's sign, Chvostek's sign, laryngospasm, or bronchospasm), hypotension, or heart failure probably or definitely caused by hypocalcemia
Acute kidney injury‡	Not applicable	Increase in the serum creatinine level of 0.3 mg/dl (26.5 μmol/liter) (or a single value >1.5 times the upper limit of the age-appropriate normal range if no baseline creatinine measurement is available) or the presence of oliguria, defined as an average urine output of <0.5 ml/kg/hr for 6 hr

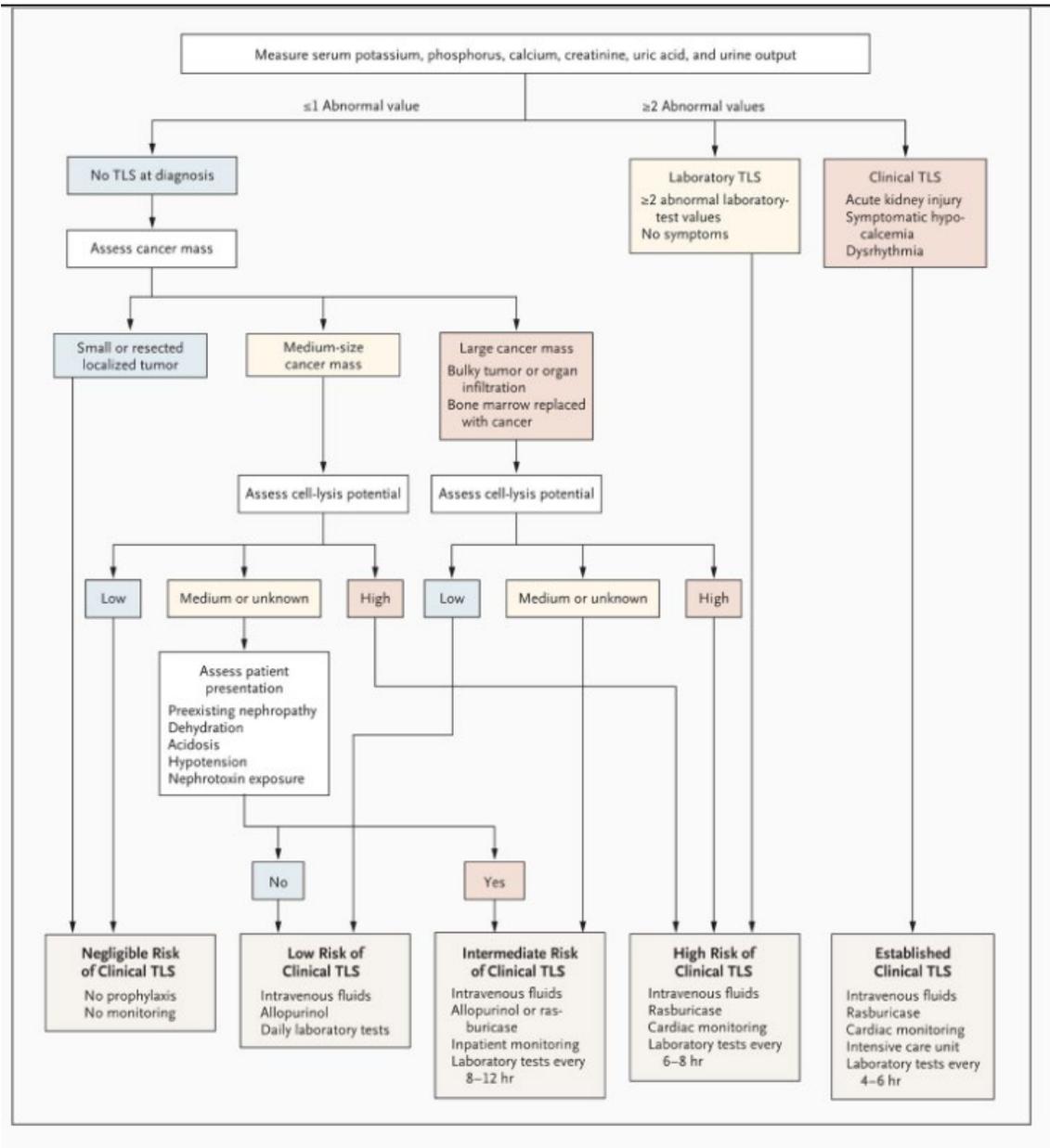
* In laboratory tumor lysis syndrome, two or more metabolic abnormalities must be present during the same 24-hour period within 3 days before the start of therapy or up to 7 days afterward. Clinical tumor lysis syndrome requires the presence of laboratory tumor lysis syndrome plus an increased creatinine level, seizures, cardiac dysrhythmia, or death.

† The corrected calcium level in milligrams per deciliter = measured calcium level in milligrams per deciliter + 0.8 × (4 - albumin in grams per deciliter).

‡ Acute kidney injury is defined as an increase in the creatinine level of at least 0.3 mg per deciliter (26.5 μmol per liter) or a period of oliguria lasting 6 hours or more. By definition, if acute kidney injury is present, the patient has clinical tumor lysis syndrome. Data about acute kidney injury are from Levin et al.¹¹

Howard SC, Jones DP, Pui CH. The tumor lysis syndrome. *N Engl J Med.* 2011 May 12;364(19):1844-54.

Figure 3: Assessment and Initial Management of the Tumor Lysis Syndrome.



Howard SC, Jones DP, Pui CH. The tumor lysis syndrome. N Engl J Med. 2011 May 12;364(19):1844-54.

Clinical Evidence

The most current consensus guidelines for the management of TLS were published by the British Committee for Standards in Hematology in 2015. The guidelines recommend up to 7 days of allopurinol prophylaxis along with increased hydration post-initiation of treatment for “intermediate risk” patients, and recommend prophylaxis with rasburicase along with increased hydration for “high risk” patients. In high-risk adults, without established clinical or laboratory TLS, the guidelines state that TLS can be prevented in the majority of patients using a single fixed dose of 3 mg of rasburicase, but patients must be followed by careful monitoring with repeat dosing if required. In high-risk children, a single dose of rasburicase 0.2 mg/kg is recommended, as current evidence is too limited to recommend a fixed 3 mg dose. For treatment of established TLS in adults and children the guidelines recommend a dose of 0.2 mg/kg/day with the length of treatment determined by clinical response. Combined use of allopurinol and rasburicase is NOT recommended as it may reduce the effectiveness of rasburicase. The National Comprehensive Cancer Network (NCCN) recommends to the use of rasburicase in patients with certain high-risk features, and state that one dose of 3 to 6 mg is frequently adequate. Redosing should be individualized.

In order to gain FDA approval, rasburicase was investigated in three studies (1 RCT and 2 single-arm studies) totaling 265 patients with acute leukemia or non-Hodgkin's lymphoma. The population was largely limited to pediatric patients (246 of 265). Rasburicase was administered as a 30-minute infusion once (n=251) or twice (n=14) daily at a dose of 0.15 or 0.2 mg/kg/dose (total daily dose 0.2 to 0.4 mg/kg/day). In a pooled analysis among patients with pre-treatment uric acid ≥ 8 mg/dL (baseline median 10.6 mg/dL) the median per-patient change in plasma uric acid concentration by 4 hours after the first dose was a decrease of 9.1 mg/dL. Among the patients with a pre-treatment plasma uric acid level < 8 mg/dL (baseline median 4.6 mg/dL), the median per-patient change in plasma uric acid concentration was a decrease of 4.1 mg/dL. Plasma uric acid concentration was maintained by 4 hours for 92%, by 24 hour for 93%, by 48 hours for 97%, by 72 hours for 99%, and by 96 hours for 100% of patients.

Rasburicase was also investigated in five studies [1 RCT (n=275) and 4 uncontrolled studies] totaling 342 adults with leukemia, lymphoma, or other hematologic malignancy. In the open-label RCT, patients at risk for hyperuricemia and TLS received at least one dose of study drug. The median age was 56 years, 62% were males, 80% were Caucasian, 66% had leukemia, 29% had lymphoma, and 18% were hyperuricemia (uric acid ≥ 7.5 g/dL) at study entry. Patients in Arm A received rasburicase 0.2 mg/kg/day IV for 5 days, Arm B received rasburicase from day 1 through day 3 followed by oral allopurinol 300 mg once a day from day 3 through day 5 (overlap on day 3), and Arm C received oral allopurinol for 5 days. The major endpoint of this study was the uric acid response rate defined as the proportion of patients with plasma uric acid levels ≤ 7.5 mg/dL from day 3 to day 7, after initiation of antihyperuricemic treatment. The response rates were, 87% (Arm A), 78% (Arm B), and 66% (Arm C). The response rate in arm A was significantly greater than in arm C ($p < 0.001$), but not for Arm B compared to Arm C. There was no difference in clinical TLS at 3%, 3%, and 4% for Arms A, B, and C, respectively.

A 2013 meta-analysis by Feng et al. examined the effectiveness of a single fixed dose of rasburicase across 10 studies (8 retrospective and 2 prospective) that evaluated adults at high risk of TLS. A comparison was made using the results from patients treated with rasburicase at the FDA-approved dosage of 0.2 mg/kg for 5 days or patients treated with allopurinol. The pool data showed that the single dose was as effective as the prolonged treatment in the control of uric acid levels, and superior to allopurinol. The authors concluded that the data suggest that single-dose rasburicase is clinically effective and cost efficient for the prophylaxis of high-risk TLS and the treatment of hyperuricemia in adult patients with cancer. A 2017 meta-analysis by Yu et al. explored the optimal single-dose regimen. The authors concluded that "for adult patients, a single 6 mg rasburicase dose is sufficient to normalize and sustain lower uric acid and creatinine levels in adults with TLS. This dose, therefore, balances cost and efficacy of treatment. The 3- and 4.5-mg single dose can be considered if the baseline uric acid level < 12 mg/dL, with close monitoring of clinical and biochemical parameters, and repeat dosing if required.

HCPCS Code

HCPCS Code	Drug Description
J2783	injection, Elitek (Rasburicase), 0.5mg

Acronyms

ALL = Acute Lymphoblastic Leukemia

AML = Acute Myeloid Leukemia

CLL = Chronic Lymphocytic Leukemia

CrCl = Creatinine Clearance

LDH = Lactate Dehydrogenase

NHL= Non-Hodgkin Lymphoma

TLS = Tumor Lysis Syndrome

ULN = Upper Limit of Normal

WBC = White Blood Cells

G6PD = Glucose-6-Phosphate Dehydrogenase

References

1. Product Information: ELITEK(R) intravenous injection, rasburicase intravenous injection. Sanofi-Aventis U.S. LLC (per FDA), Bridgewater, NJ, 2022.
2. Jones GL, Will A, Jackson GH, et al: Guidelines for the management of tumor lysis syndrome in adults and children with hematological malignancies on behalf of the British Committee for Standards in Haematology. *Br J Haematol* 2015; 169(5):661-671. PubMed Article: https://www.ncbi.nlm.nih.gov/pubmed?cmd=Link&dbFrom=PubMed&from_uid=25876990
3. Cortes J, Moore JO, Maziarz RT, et al: Control of plasma uric acid in adults at risk for tumor Lysis syndrome: efficacy and safety of rasburicase alone and rasburicase followed by allopurinol compared with allopurinol alone--results of a multicenter phase III study. *J Clin Oncol* 2010; 28(27):4207-4213. PubMed Article: https://www.ncbi.nlm.nih.gov/pubmed?cmd=Link&dbFrom=PubMed&from_uid=20713865
4. Yu X, Liu L, Nie X, et al: The optimal single-dose regimen of rasburicase for management of tumor lysis syndrome in children and adults: a systematic review and meta-analysis. *J Clin Pharm Ther* 2017; 42(1):18-26. PubMed Article: https://www.ncbi.nlm.nih.gov/pubmed?cmd=Link&dbFrom=PubMed&from_uid=27888526
5. Coiffier B, Altman A, Pui CH, et al: Guidelines for the management of pediatric and adult tumor lysis syndrome: an evidence-based review. *J Clin Oncol* 2008; 26(16):2767-2778. PubMed Article: https://www.ncbi.nlm.nih.gov/pubmed?cmd=Link&dbFrom=PubMed&from_uid=18509186
6. Pui C-H, Jeha S, Irwin D, et al: Recombinant urate oxidase (rasburicase) in the prevention and treatment of malignancy-associated hyperuricemia in pediatric and adult patients: results of a compassionate-use trial. *Leukemia* 2001a; 15:1505-1509.
7. Brant JM: Rasburicase: an innovative new treatment for hyperuricemia associated with tumor lysis syndrome. *Clin J Oncol Nurs* 2002; 6(1):12-16.
8. Clemmons AB, Ensley E, Hoge S, et al: Fixed-dose rasburicase in overweight and obese patients versus normal-weight patients. *Ann Pharmacother* 2014; 48(9):1152-1158.
9. DRUGDEX System (electronic version). Truven Health Analytics, Greenwood Village, Colorado, USA. Available at: <http://www.micromedexsolutions.com/>. May 06, 2025.
10. Vines AN, Shanholtz CB, and Thompson JL. Fixed dose rasburicase 6mg for hyperuricemia and tumor lysis syndrome in high-risk cancer patients. *Ann Pharmacotherapy* 2010; 44(10): 1529-1537
11. Trifilio SM, Pi J, Zook J, et al. Effectiveness of a single 3 mg rasburicase dose for the management of hyperuricemia in patients with hematological malignancies. *Bone Marrow Transplant*. 2011; 46(6): 800-805.
12. Vadhan-Raj S, Fayad LE, Fanale MA, et al. a randomized trial of a single dose rasburicase versus five-daily doses in patients at risk for tumor lysis syndrome. *Ann Oncol*. 2012 Jun; 23(6); 1640-5.
13. Savva DA, Herrera N, and Rohatgi R. Comparison of fixed versus traditional weight based dosing of rasburicase in a pediatric population. *Pediatr Blood Cancer*. 2018 Jun 15:e27236.(Epub ahead of print).
14. National Comprehensive Cancer Network. NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines).B-cell Lymphomas (Version 2.2025); page NHODG-B 1 OF 5. Available from: https://www.nccn.org/professionals/physician_gls/pdf/b-cell.pdf

15. National Comprehensive Cancer Network. NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines). Acute Lymphoblastic Leukemia (Version 1.2025); page MS-66. Available from: https://www.nccn.org/professionals/physician_gls/pdf/all.pdf
16. Howard SC, Jones DP, Pui CH. The tumor lysis syndrome. *N Engl J Med*. 2011 May 12;364(19):1844-54. doi: 10.1056/NEJMra0904569. Erratum in: *N Engl J Med*. 2018 Sep 13;379(11):1094.
17. Cairo MS, Coiffier B, Reiter A, Younes A; TLS Expert Panel. Recommendations for the evaluation of risk and prophylaxis of tumour lysis syndrome (TLS) in adults and children with malignant diseases: an expert TLS panel consensus. *Br J Haematol*. 2010 May;149(4):578-86. doi: 10.1111/j.1365-2141.2010.08143.x. Epub 2010 Mar 16. PMID: 20331465.

Policy History/Revision Information

Date Revised	Type of Changes (Significant or Minor)	List Significant Changes and/or Status of policy
02/01/19	Significant	New drug criteria created for Elitek (Rasburicase)-Eric McDermott, PharmD.
02/18/22	Minor	Criteria updated per new template, added hyperlinks, HCPCS code. Added options of any clinical setting of sensitive tumor with high risk of TLS & determination will be made on case-by-case basis under unusual circumstances – Brent Bryant, PharmD
08/02/23	Minor	Annual criteria revision. Defined “intermediate risk” per NCCN. Mira Dawood, PharmD
07/31/24	None	Annual revision, No updates to the policy – Pathik Tripathi, PharmD
05/31/2025	Minor	Updated diagnosis-specific criteria, added dosing table, added information to background and updated references. MVader, PharmD.
07/25/25	Minor	Updated disclaimer section. S.Zaid, PharmD