

rilzabrutinib (Wayrilz™)

Policy # 00953

Original Effective Date: 02/01/2026

Current Effective Date: 02/01/2026

Applies to all products administered or underwritten by Blue Cross and Blue Shield of Louisiana and its subsidiary, HMO Louisiana, Inc. (collectively referred to as the “Company”), unless otherwise provided in the applicable contract. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.

Investigational or experimental services are not covered. This includes any drug, device, procedure, or service provided under the investigational arm of a clinical trial or clinical study. These services are excluded from coverage under benefits.

When Services May Be Eligible for Coverage

Coverage for eligible medical treatments or procedures, drugs, devices or biological products may be provided only if:

- *Benefits are available in the member’s contract/certificate, and*
- *Medical necessity criteria and guidelines are met.*

Based on review of available data, the Company may consider rilzabrutinib (Wayrilz™)† for the treatment of immune thrombocytopenia to be **eligible for coverage.****

Patient Selection Criteria

Coverage eligibility for rilzabrutinib (Wayrilz) will be considered when the following criteria are met:

- Patient has a diagnosis of chronic or persistent immune thrombocytopenia (ITP); AND
- Patient is greater than or equal to 18 years of age; AND
- Patient meets ONE of the following:
 - Patient has a platelet count < 30 x 10⁹/L; OR
 - Patient has a platelet count < 50 x 10⁹/L AND is at an increased risk of bleeding (e.g., older age, nonsteroidal anti-inflammatory drug [NSAID] use, or prior bleeding event); AND

*(Note: This specific patient selection criterion is an additional Company requirement for coverage eligibility and will be denied as not medically necessary** if not met).*

- Patient has tried and failed (e.g., intolerance or inadequate response) at least ONE of the following alternative therapies: corticosteroids (e.g., dexamethasone, prednisone), intravenous immunoglobulin (IVIG), anti-D immunoglobulin, a thrombopoietin receptor agonist (e.g., eltrombopag [Promacta®]‡, romiplostim [NPlate®]‡), or rituximab (Rituxan®‡, biosimilars).

When Services Are Considered Not Medically Necessary

Based on review of available data, the Company considers the use of rilzabrutinib (Wayrilz) when the patient has a platelet count between 30-50 x 10⁹/L without an increased risk of bleeding or a platelet count greater than 50 x 10⁹/L to be **not medically necessary.****

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When Services Are Considered Investigational

Coverage is not available for investigational medical treatments or procedures, drugs, devices or biological products.

Based on review of available data, the Company considers the use of rilzabrutinib (Wayrilz) when the patient selection criteria are not met (except those denoted above as **not medically necessary****) to be **investigational**.*

Background/Overview

Wayrilz is a Bruton's tyrosine kinase (BTK) inhibitor indicated for the treatment of persistent or chronic immune thrombocytopenia (ITP) in adults who have had an insufficient response to a previous treatment. It works by immune modulation, including inhibition of B cell activation and interruption of antibody-coated cell phagocytosis by the Fcγ receptor found in the spleen and liver. This novel mechanism of action addresses the underlying causes of disease and may present an advantage in patients unable to tolerate standard treatments such as corticosteroids and thrombopoietin receptor agonists. Wayrilz should be dosed as 400 mg by mouth twice daily regardless of patient's weight and platelet count.

ITP is an acquired condition of thrombocytopenia in which autoantibodies destroy the platelets and also affect megakaryocytes and impair platelet production. ITP has previously been called idiopathic thrombocytopenic purpura, immune thrombocytopenic purpura, or autoimmune thrombocytopenic purpura, but these terms have been replaced by immune thrombocytopenia (ITP) to reflect the known immunologic mechanism and absence of purpura in some patients. This condition is further classified into newly diagnosed, persistent, or chronic disease based on the time elapsed since diagnosis. ITP is considered persistent when it has been 3-12 months since diagnosis and chronic if it has been more than 12 months. The 2019 American Society of Hematology (ASH) guidelines state that first-line treatment for adults with ITP includes corticosteroids. For patients who are corticosteroid-dependent or do not respond to corticosteroids, thrombopoietin receptor agonists or splenectomy are recommended. Rituximab may also be considered but is less preferred than the thrombopoietin receptor agonist or splenectomy. These guidelines have not been updated to include newer therapies such as Wayrilz or fostamitinib (Tavalisse®)†.

FDA or Other Governmental Regulatory Approval

U.S. Food and Drug Administration (FDA)

Wayrilz was approved in August 2025 for the treatment of adult patients with persistent or chronic immune thrombocytopenia (ITP) who have had an insufficient response to a previous treatment.

Rationale/Source

This medical policy was developed through consideration of peer-reviewed medical literature generally recognized by the relevant medical community, U.S. Food and Drug Administration approval status, nationally accepted standards of medical practice and accepted standards of medical practice in this community, technology evaluation centers, reference to regulations, other plan medical policies, and accredited national guidelines.

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The safety and efficacy of Wayrilz in adult patients with primary persistent or chronic ITP was evaluated in a randomized, double-blind, placebo-controlled, parallel-group study consisting of 24 weeks of blinded treatment followed by an open-label period. Patients received an initial 12 weeks of double-blind period treatment. Those who achieved platelet count response at 12 weeks were eligible to continue the full 24-week double-blind period. The patients enrolled in the study had an unsustained response to either intravenous immunoglobulin (IVIG/anti-D) or corticosteroid or had a documented intolerance or insufficient response to any appropriate course of standard-of-care ITP therapy. Patients were randomized 2:1 to receive Wayrilz 400 mg or placebo twice daily and randomization was stratified based on prior splenectomy and severity of thrombocytopenia. Concomitant ITP medicines were allowed at stable doses at least 2 weeks before the start of the study and throughout the double-blind period.

In this study, 202 patients were randomized and treated, 133 to the Wayrilz group and 69 to the placebo group. At baseline, 93% of patients had chronic ITP (i.e., for 1 year or longer), with a median time since ITP diagnosis of 7.69 years (Range: 0.3, 52.2), and 28% had undergone splenectomy. The median platelet count was $15.3 \times 10^9/L$ with almost half (48%) less than $15 \times 10^9/L$. The median number of prior therapies, including splenectomy, was 4 (range: 1, 15). At baseline, 66% of patients received both corticosteroids and thrombopoietin receptor agonists.

During the double-blind period, the median duration of exposure was 98 days (range: 22 to 182) and 84 days (range: 17 to 173) for the Wayrilz group and placebo group, respectively. The cumulative duration of treatment exposure was 44 participant-years and 18 participant-years for the Wayrilz and placebo groups, respectively. Concomitant use of corticosteroids and/or thrombopoietin receptor agonists with study drug occurred in 60% and 67% of patients in the Wayrilz and placebo arms, respectively.

During the first 12 weeks of the double-blind period, 85 (63.9%) patients and 22 (31.9%) patients in the Wayrilz group and placebo group, respectively, achieved platelet count response ($\geq 50 \times 10^9/L$ or between $30 \times 10^9/L$ and $< 50 \times 10^9/L$ and doubled from baseline). Those who achieved platelet count response were eligible to continue the double-blind period.

The efficacy of Wayrilz was based on durable platelet response. A durable platelet response was defined as a weekly platelet count $\geq 50 \times 10^9/L$ for $\geq$ two-thirds of at least 8 non-missing weekly scheduled platelet measurements during the last 12 weeks of the 24-week double-blind period in the absence of rescue therapy, provided that at least 2 non-missing weekly scheduled platelet measurements were $\geq 50 \times 10^9/L$ during the last 6 weeks of the double-blind period. In the Wayrilz group, 31% of participants met this definition (95% CI 16.12, 30.49) compared to 0 in the placebo group ($p < 0.0001$).

References

1. Wayrilz [package insert]. Genzyme Corporation. Cambridge, MA. Updated August 2025.
2. Wayrilz Drug Evaluation. Express Scripts. Updated September 2025.

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Policy History

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01/05/2026 Medical Policy Committee review

01/07/2026 Medical Policy Implementation Committee approval. New policy.

Next Scheduled Review Date: 01/2027

*Investigational – A medical treatment, procedure, drug, device, or biological product is Investigational if the effectiveness has not been clearly tested and it has not been incorporated into standard medical practice. Any determination we make that a medical treatment, procedure, drug, device, or biological product is Investigational will be based on a consideration of the following:

- A. Whether the medical treatment, procedure, drug, device, or biological product can be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA) and whether such approval has been granted at the time the medical treatment, procedure, drug, device, or biological product is sought to be furnished; or
- B. Whether the medical treatment, procedure, drug, device, or biological product requires further studies or clinical trials to determine its maximum tolerated dose, toxicity, safety, effectiveness, or effectiveness as compared with the standard means of treatment or diagnosis, must improve health outcomes, according to the consensus of opinion among experts as shown by reliable evidence, including:
 1. Consultation with technology evaluation center(s);
 2. Credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community; or
 3. Reference to federal regulations.

**Medically Necessary (or “Medical Necessity”) - Health care services, treatment, procedures, equipment, drugs, devices, items or supplies that a Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

- A. In accordance with nationally accepted standards of medical practice;
- B. Clinically appropriate, in terms of type, frequency, extent, level of care, site and duration, and considered effective for the patient's illness, injury or disease; and
- C. Not primarily for the personal comfort or convenience of the patient, physician or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For these purposes, “nationally accepted standards of medical practice” means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of Physicians practicing in relevant clinical areas and any other relevant factors.

‡ Indicated trademarks are the registered trademarks of their respective owners.

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NOTICE: If the Patient's health insurance contract contains language that differs from the BCBSLA Medical Policy definition noted above, the definition in the health insurance contract will be relied upon for specific coverage determinations.

NOTICE: Medical Policies are scientific based opinions, provided solely for coverage and informational purposes. Medical Policies should not be construed to suggest that the Company recommends, advocates, requires, encourages, or discourages any particular treatment, procedure, or service, or any particular course of treatment, procedure, or service.

NOTICE: Federal and State law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage.

NOTICE: If an authorization for an ongoing course of treatment has been provided to a member and the member changes from one health plan to another health plan (e.g., a member moves from carrier A to Louisiana Blue), Louisiana Blue may honor the previous health plan's authorization for the same service under the same type of in-network benefit for a 90-day transition period. Documentation of the authorization for the ongoing course of treatment from the previous health plan must be provided to us by the member or their provider and the services provided for the course of treatment must otherwise be a covered service under the Louisiana Blue health plan. This provision does not apply to medications covered under the plan's pharmacy benefit.