Clinical Policy: Reslizumab (Cinqair)

Reference Number: CP.PHAR.223
Effective Date: 05.16
Last Review Date: 02.18
Line of Business: Commercial, Medicaid

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Reslizumab (Cinqair®) is an interleukin-5 antagonist monoclonal antibody (IgG1 kappa).

FDA Approved Indication(s)

Cinqair is indicated for add-on maintenance treatment of patients with severe asthma aged 18 years and older, and with an eosinophilic phenotype.

Limitation(s) of use: Cinqair is not indicated for treatment of other eosinophilic conditions. Cinqair is not indicated for the relief of acute bronchospasm or status asthmaticus.

Policy/Criteria

Provider must submit documentation (including such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation® that Cinqair is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Severe Asthma (must meet all):

1. Diagnosis of asthma with absolute blood eosinophil count ≥ 400 cells/mcL within the past 3 months;
2. Prescribed by or in consultation with an allergist or pulmonologist;
3. Age ≥ 18 years;
4. Member has experienced ≥ 2 exacerbations within 12 months, requiring any of the following despite adherent use of controller therapy (i.e., high dose inhaled corticosteroid (ICS) plus either a long acting beta-2 agonist (LABA) or leukotriene modifier (LTRA) if LABA contraindication/intolerance):
   a. Oral/systemic corticosteroid treatment (or increase in dose if already on oral corticosteroid);
   b. Urgent care visit or hospital admission;
   c. Intubation;
5. Cinqair is prescribed concomitantly with an ICS plus a LABA. If a LABA is contraindicated, a second controller agent (e.g., LTRA) must be used in combination with an ICS;
6. Prescribed dose does not exceed 3mg/kg once every 4 weeks.

Approval duration: 6 months

B. Other diagnoses/indications
1. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.CPA.09 for commercial and CP.PMN.53 for Medicaid.

II. Continued Therapy

A. Severe Asthma (must meet all)**:**
1. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
2. Demonstrated adherence to asthma controller therapy that includes an ICS plus either an LABA or LTRA;
3. Member is responding positively to therapy (e.g.: reduction in exacerbations or corticosteroid dose, improvement in forced expiratory volume$_1$ over one second) since baseline; reduction in the use of rescue therapy);
4. If request is for a dose increase, new dose does not exceed 3mg/kg once every 4 weeks.

Approval duration:
Medicaid - 12 months
Commercial – 6 months or member's renewal period, whichever is longer

B. Other diagnoses/indications (must meet 1 or 2)**:**
1. Currently receiving medication via Centene benefit and documentation supports positive response to therapy.
   Approval duration: Duration of request or 6 months (whichever is less); or
2. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.CPA.09 for commercial and CP.PMN.53 for Medicaid.

III. Diagnoses/Indications for which coverage is NOT authorized:

A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies – CP.CPA.09 for commercial and CP.PMN.53 for Medicaid or evidence of coverage documents;

B. Acute bronchospasm or status asthmaticus.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key
ICS: inhaled corticosteroid
IL: interleukin
LABA: Long-acting beta-agonist
LTRA: leukotriene modifier

Appendix B: Therapeutic Alternatives

This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent and may require prior authorization.

Drug	Dosing Regimen	Dose/Limit/Maximum Dose
Inhaled corticosteroids		
Beclomethasone (Qvar®)	40 mcg, 80 mcg/actuation 1-4 actuations twice daily	4 actuations twice daily
Budesonide (Pulmicort®)	180 mcg/actuation 1-2 actuations once or twice daily	2 actuations twice daily
Alvesco® (ciclesonide)	80 mcg, 160 mcg per actuation 1-2 actuations twice daily	2 actuations twice daily
Aerospan® (flunisolide)	80 mcg per actuation 1-2 actuations twice daily	2 actuations twice daily
Flovent® (fluticasone propionate)	44-220 mcg per actuation 1-2 actuations twice daily	2 actuations twice daily
Arnuity Ellipta® (fluticasone furoate)	100 mcg, 200 mcg per actuation 1 actuation once daily	1 actuation once daily
Asmanex® (mometasone)	110 mcg, 220 mcg 1-2 inhalations once to twice daily	2 inhalations twice daily
Spiriva Respimat™ (tiotropium bromide)	2 inhalations (1.25 mcg each) Once daily	2 inhalations (1.25 mcg each) Once daily
Long-acting beta-agonists		
Foradil® (formoterol)	12 mcg capsule for inhalation 1 capsule twice daily	24 mcg per day
Serevent® (salmeterol)	50 mcg per dose 1 inhalation twice daily	1 inhalation twice daily
Combination products		
Dulera® (mometasone/ formoterol)	100/5 mcg, 200/5 mcg per actuation 2 actuations twice daily	4 actuations per day
Breo Ellipta® (fluticasone/ vilanterol)	100/25 mcg, 200/25 mcg per actuation 1 actuation once daily	1 actuation once daily
Advair® (fluticasone/ salmeterol)	100/50 mcg, 250/50 mcg, 500/50 mcg per actuation 1 actuation twice daily	1 actuation twice daily

Drug	Dosing Regimen	Dose/Limit/Maximum Dose
Symbicort® (budesonide/ formoterol)	80 mcg/4.5 mcg; 160 mcg/4.5 mcg per actuation 1-2 actuations twice daily	2 actuations twice daily
Antileukotriene agents		
Montelukast (Singulair®)	4 to 10 mg PO QD	10 mg per day
Zafirlukast (Accolate®)	10 to 20 mg PO BID	40 mg per day
Zyflo® (zileuton)	IR: 600 mg PO QID SR: 1200 mg PO BID	2400 mg per day
Oral glucocorticoids		
Dexamethasone (Decadron)	0.75 to 9 mg/day PO in 2 to 4 divided doses	Varies
Methylprednisolone (Medrol)	40 to 80 mg PO in 1 to 2 divided doses	Varies

Therapeutic alternatives are listed as Brand name® (generic) when the drug is available by brand name only and generic (Brand name®) when the drug is available by both brand and generic.

Appendix C: General Information

- Cinqair is not indicated for treatment of other eosinophilic conditions or relief of acute bronchospasm or status asthmaticus.
- Asthma exacerbations (primary endpoint) was defined as 1) use of systemic steroid, or ≥2-fold increase in the use of ICS for 3 or more days; 2) asthma related emergency treatment by nebulizer, a visit to the emergency department (ED) or asthma related hospitalization.
- Controller medications are: inhaled glucocorticoids (Flovent, Pulmicort, Qvar, Asmanex), long-acting beta-agonists (LABAs) such as salmeterol, formoterol, or vilanterol, and antileukotriene agents (montelukast [Singulair®], zafirlukast [Accolate®] or Zyflo® [zileuton]). Theophylline is also a controller agent, however, it is not as efficacious as LABAs.
- Patients could potentially meet criteria for both Xolair and Cinqair. The combination has not been studied. Approximately 30% of patients in the Nucala study also were candidates for therapy with Xolair.

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Severe Asthma	3 mg/kg once every 4 weeks by IV infusion over 20-50 minutes. Cinqair should be administered in a healthcare setting by a healthcare professional prepared to manage anaphylaxis.	3 mg/kg every 4 weeks

VI. Product Availability

Single-use vial: 100 mg/10 mL solution

VII. References

1. Cinqair prescribing information. Frazer, PA: Teva Pharmaceutical Industries Ltd.; May 2016. Available at http://www.cinqair.com/pdf/PrescribingInformation.pdf. Accessed November 2017.
2. National Asthma Education and Prevention Program: Expert panel report III: Guidelines for the diagnosis and management of asthma. Bethesda, MD: National Heart, Lung, and Blood Institute, 2007. (NIH publication no. 08-4051). Available at http://www.nhlbi.nih.gov/health-pro/guidelines/current/asthma-guidelines. Accessed November 2017.
3. Corren J, Weinstein S, Janka L, Zangrilli J, Garin M. Phase 3 study of reslizumab in patients with poorly controlled asthma: effects across a broad range of eosinophil counts. *Chest.* 2016; 150(4): 799-810.
4. Maselli DJ, Velez MI, Rogers L. Reslizumab in the management of poorly controlled asthma: The data so far. *Journal of Asthma and Allergy.* August 31, 2016; 9: 155-162.
5. Clinical Pharmacology [database online]. Tampa, FL: Gold Standard, Inc.; 2017. Available at: http://www.clinicalpharmacology.com. Accessed November 2017.

Coding Implications

Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

HCPCS Codes	Description
J2786	Injection, reslizumab, 1 mg

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy developed.	05.16	05.16
An absolute blood eosinophil count ≥400 cells/mcL is added. Controller trial requirements are edited in the initial and renewal criteria and a smoking cessation line item is added. The contraindication/hypersensitivity black box warning of anaphylaxis is not included. Efficacy statement is added to renewal criteria. Approval durations changed to 6 and 12 months.	03.17	04.17
1Q18 annual review: - Combined Medicaid and Commercial policies - No significant changes from previously approved corporate policy - Removed smoking cessation program requirements from existing Medicaid policy as this cannot be enforced. - Added "Acute bronchospasm or status astmaticus" to	11.07.17	02.18

Reviews, Revisions, and Approvals	Date	P&T Approval Date
section III as indications for which coverage is not authorized per PI - References reviewed and updated		

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

Note:
For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.