Clinical Policy: Reslizumab (Cinqair)
Reference Number: CP.PHAR.223
Effective Date: 05.16
Last Review Date: 02.19
Line of Business: Commercial, Medicaid

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

Description
Reslizumab (Cinqair®) is a humanized 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 (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;
      2. Member has an absolute blood eosinophil count ≥ 400 cells/mcL within the past 3 months;
      3. Prescribed by or in consultation with an allergist, immunologist, or pulmonologist;
      4. Age ≥ 18 years;
      5. Member has experienced ≥ 2 exacerbations within 12 months, requiring any of the following despite adherent use of controller therapy (i.e., medium- to 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;
      6. Cinqair is prescribed concomitantly with an ICS plus either a LABA or LTRA;
      7. Dose does not exceed 3 mg/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 (examples may include but are not limited to a reduction in exacerbations or corticosteroid dose, improvement in forced expiratory volume\textsubscript{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 3 mg/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
   GINA: Global Initiative for Asthma
   ICS: inhaled corticosteroid
   FDA: Food and Drug Administration
   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.
<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Dosing Regimen</th>
<th>Dose Limit/Maximum Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ICS (medium – high dose)</strong></td>
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</tbody>
</table>
| Qvar® (beclomethasone)        | > 200 mcg/day  
40 mcg, 80 mcg per actuation  
1-4 actuations BID | 4 actuations BID        |
| budesonide (Pulmicort®)       | > 400 mcg/day  
90 mcg, 180 mcg per actuation  
2-4 actuations BID | 2 actuations BID        |
| Alvesco® (ciclesonide)        | > 160 mcg/day  
80 mcg, 160 mcg per actuation  
1-2 actuations BID | 2 actuations BID        |
| Aerospan® (flunisolide)       | > 320 mcg/day  
80 mcg per actuation  
2-4 actuations BID | 2 actuations BID        |
| Flovent® (fluticasone propionate) | > 250 mcg/day  
44-250 mcg per actuation  
2-4 actuations BID | 2 actuations BID        |
| Arnuiity Ellipta® (fluticasone furoate) | 200 mcg/day  
100 mcg, 200 mcg per actuation  
1 actuation QD | 1 actuation QD        |
| Asmanex® (mometasone)         | >220 mcg/day  
HFA: 100 mcg, 200 mcg per actuation  
Twisthaler: 110 mcg, 220 mcg per actuation  
1-2 actuations QD to BID | 2 inhalations BID        |
| **LABA**                      |                                                   |                         |
| Serevent® (salmeterol)        | 50 mcg per dose  
1 inhalation BID | 1 inhalation BID        |
| **Combination products (ICS + LABA)** |                                                   |                         |
| Dulera® (mometasone/formoterol) | 100/5 mcg, 200/5 mcg per actuation  
2 actuations BID | 4 actuations per day |
| Breo Ellipta® (fluticasone/vilanterol) | 100/25 mcg, 200/25 mcg per actuation  
1 actuation QD | 1 actuation QD        |
| Advair® (fluticasone/salmeterol) | Diskus: 100/50 mcg, 250/50 mcg, 500/50 mcg per actuation  
HFA: 45/21 mcg, 115/21 mcg, 230/21 mcg per actuation  
1 actuation BID | 1 actuation BID        |
| fluticasone/salmeterol (Airduo RespiClick®) | 55/13 mcg, 113/14 mcg, 232/14 mcg per actuation  
1 actuation BID | 1 actuation BID        |
| Symbicort® (budesonide/formoterol) | 80 mcg/4.5 mcg, 160 mcg/4.5 mcg per actuation  
2 actuations BID | 2 actuations BID        |
Drug Name | Dosing Regimen | Dose Limit/ Maximum Dose
--- | --- | ---
**LTRA**
montelukast (Singulair®) | 4 to 10 mg PO QD | 10 mg per day
zafirlukast (Accolate®) | 10 to 20 mg PO BID | 40 mg per day
zileuton ER (Zyflo® CR) | 1200 mg PO BID | 2400 mg per day
Zyflo® (zileuton) | 600 mg PO QID | 2400 mg per day

**Oral corticosteroids**
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
prednisolone (Millipred®, Orapred ODT®) | 40 to 80 mg PO in 1 to 2 divided doses | Varies
prednisone (Deltasone®) | 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: Contraindications/Boxed Warnings**
- Contraindication(s): hypersensitivity
- Boxed warning(s): none reported

**Appendix D: 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.
- Positive response to therapy for asthma may include reduction in exacerbations or corticosteroid dose, improvement in forced expiratory volume over one second since baseline, or reduction in the use of rescue therapy.
V. Dosage and Administration

<table>
<thead>
<tr>
<th>Indication</th>
<th>Dosing Regimen</th>
<th>Maximum Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Severe asthma</td>
<td>3 mg/kg IV every 4 weeks. Cinqair should be administered in a healthcare setting by a healthcare professional prepared to manage anaphylaxis.</td>
<td>3 mg/kg every 4 weeks</td>
</tr>
</tbody>
</table>

VI. Product Availability

Single-use vial: 100 mg/10 mL solution

VII. References


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.

<table>
<thead>
<tr>
<th>HCPCS Codes</th>
<th>Description</th>
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<tbody>
<tr>
<td>J2786</td>
<td>Injection, reslizumab, 1 mg</td>
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Reviews, Revisions, and Approvals

<table>
<thead>
<tr>
<th>Date</th>
<th>P&amp;T Approval Date</th>
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<tbody>
<tr>
<td>05.16</td>
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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
Reviews, Revisions, and Approvals

<table>
<thead>
<tr>
<th>Date</th>
<th>P&amp;T Approval Date</th>
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<tbody>
<tr>
<td>11.07.17</td>
<td>02.18</td>
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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.

IQ18 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 section III as indications for which coverage is not authorized per PI
- References reviewed and updated

1Q 2019 annual review: modified ICS requirement to include medium dose ICS per GINA 2018 recommendations; added option for immunologist prescribing; references reviewed and updated.

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<thead>
<tr>
<th>Date</th>
<th>P&amp;T Approval Date</th>
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<tbody>
<tr>
<td>10.11.18</td>
<td>02.19</td>
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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.

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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.

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