Clinical Policy: Reslizumab (Cinqair)
Reference Number: CP.PHAR.223
Effective Date: 06.01.16
Last Review Date: 02.20
Line of Business: Commercial, HIM, 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 concurrently with an ICS plus either a LABA or LTRA;
      7. Cinqair is not prescribed concurrently with Fasenra®, Nucala®, Dupixent®, or Xolair®;
8. 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, HIM.PHAR.21 for health insurance marketplace, 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: reduction in exacerbations or corticosteroid dose, improvement in forced expiratory volume over one second since baseline, reduction in the use of rescue therapy);
   4. Cinqair is not prescribed concurrently with Fasenra, Nucala, Dupixent, or Xolair;
   5. If request is for a dose increase, new dose does not exceed 3 mg/kg once every 4 weeks.
   Approval duration:
   Medicaid/HIM – 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, HIM.PHAR.21 for health insurance marketplace, 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, HIM.PHAR.21 for health insurance marketplace, 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>
<td></td>
<td></td>
</tr>
<tr>
<td>Qvar® (beclomethasone)</td>
<td>&gt; 200 mcg/day 40 mcg, 80 mcg per actuation 1-4 actuations BID</td>
<td>4 actuations BID</td>
</tr>
<tr>
<td>budesonide (Pulmicort®)</td>
<td>&gt; 400 mcg/day 90 mcg, 180 mcg per actuation 2-4 actuations BID</td>
<td>2 actuations BID</td>
</tr>
<tr>
<td>Alvesco® (ciclesonide)</td>
<td>&gt; 160 mcg/day 80 mcg, 160 mcg per actuation 1-2 actuations BID</td>
<td>2 actuations BID</td>
</tr>
<tr>
<td>Aerospan® (flunisolide)</td>
<td>&gt; 320 mcg/day 80 mcg per actuation 2-4 actuations BID</td>
<td>2 actuations BID</td>
</tr>
<tr>
<td>Flovent® (fluticasone propionate)</td>
<td>&gt; 250 mcg/day 44-250 mcg per actuation 2-4 actuations BID</td>
<td>2 actuations BID</td>
</tr>
<tr>
<td>Arnuity Ellipta® (fluticasone furoate)</td>
<td>200 mcg/day 100 mcg, 200 mcg per actuation 1 actuation QD</td>
<td>1 actuation QD</td>
</tr>
<tr>
<td>Asmanex® (mometasone)</td>
<td>&gt;220 mcg/day HFA: 100 mcg, 200 mcg per actuation Twisthaler: 110 mcg, 220 mcg per actuation 1-2 actuations QD to BID</td>
<td>2 inhalations BID</td>
</tr>
<tr>
<td><strong>LABA</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Serevent® (salmeterol)</td>
<td>50 mcg per dose 1 inhalation BID</td>
<td>1 inhalation BID</td>
</tr>
<tr>
<td><strong>Combination products (ICS + LABA)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dulera® (mometasone/formoterol)</td>
<td>100/5 mcg, 200/5 mcg per actuation 2 actuations BID</td>
<td>4 actuations per day</td>
</tr>
<tr>
<td>Breo Ellipta® (fluticasone/vilanterol)</td>
<td>100/25 mcg, 200/25 mcg per actuation 1 actuation QD</td>
<td>1 actuation QD</td>
</tr>
<tr>
<td>Advair® (fluticasone/salmeterol)</td>
<td>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</td>
<td>1 actuation BID</td>
</tr>
</tbody>
</table>
### Drug Name | Dosing Regimen | Dose Limit/ Maximum Dose
--- | --- | ---
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

**LTRA**
- montelukast (Singular®) | 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): anaphylaxis

### Appendix D: General Information
- 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 [Singular], zafirlukast [Accolate] or Zyflo [zileuton]). Theophylline is also a controller agent; however, it is not as efficacious as LABAs.
- Patients could potentially meet asthma criteria for both Xolair and Cinqair. The combination has not been studied. Approximately 30% of patients in the Nucala MENSA study also were candidates for therapy with Xolair.
- Lab results for blood eosinophil counts can be converted into cells/mcL using the following unit conversion calculator: [https://www.gsksource.com/pharma/content/micro-sites/nucala-eos-calc/index.html](https://www.gsksource.com/pharma/content/micro-sites/nucala-eos-calc/index.html)
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</td>
<td>3 mg/kg every 4 weeks</td>
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<tr>
<td></td>
<td>Cinqair should be administered in a healthcare setting by a healthcare professional prepared to manage anaphylaxis.</td>
<td></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>
</tr>
</thead>
<tbody>
<tr>
<td>J2786</td>
<td>Injection, reslizumab, 1 mg</td>
</tr>
</tbody>
</table>

Reviews, Revisions, and Approvals

<table>
<thead>
<tr>
<th>Date</th>
<th>P&amp;T Approval Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>05.16</td>
<td>05.16</td>
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</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Reviews, Revisions, and Approvals</th>
<th>Date</th>
<th>P&amp;T Approval Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1Q18 annual review:</td>
<td>11.07.17</td>
<td>02.18</td>
</tr>
<tr>
<td>- Combined Medicaid and Commercial policies</td>
<td></td>
<td></td>
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<tr>
<td>- No significant changes from previously approved corporate policy</td>
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<tr>
<td>- Removed smoking cessation program requirements from existing Medicaid policy as this cannot be enforced.</td>
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<tr>
<td>- Added “Acute bronchospasm or status astmaticus” to section III as indications for which coverage is not authorized per PI</td>
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<td></td>
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<tr>
<td>- References reviewed and updated</td>
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<tr>
<td>1Q 2019 annual review:</td>
<td>10.11.18</td>
<td>02.19</td>
</tr>
<tr>
<td>modified ICS requirement to include medium dose ICS per GINA 2018 recommendations; added option for immunologist prescribing; references reviewed and updated</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1Q 2020 annual review:</td>
<td>11.07.19</td>
<td>02.20</td>
</tr>
<tr>
<td>added HIM line of business; added requirement that Cinqair is not prescribed concurrently with other biologic therapies for asthma; references reviewed and updated</td>
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</tr>
</tbody>
</table>

**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.

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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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