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Medical benefit drug policies are a source for BCBSM and BCN medical policy information only. These documents are not to be used to determine benefits or reimbursement. Please reference the appropriate certificate or contract for benefit information. This policy may be updated and therefore subject to change.

**Effective Date: 10/03/2024**

**Cinqair<sup>®</sup> (reslizumab)**

**HCPCS: J2786**

**Policy:**

*Requests must be supported by submission of chart notes and patient specific documentation.*

- A. Coverage of the requested drug is provided when all the following are met:
  - a. FDA approved age
  - b. FDA approved indication
  - c. Patient is currently receiving, and will continue to receive standard of care regimen
  - d. Severe eosinophilic asthma identified by:
    - i. Blood eosinophils greater than or equal to 150 cells/microliter at initiation of treatment
  - e. Chronic administration of systemic corticosteroids or high dose inhaled corticosteroids (listed in table 1) in combination with
    - i. Long acting inhaled  $\beta$ 2 agonist modifier for at least 3 months fails to maintain adequate control  
OR
    - ii. leukotriene modifier for at least 3 months fails to maintain adequate control  
OR
    - iii. LAMA (long acting muscarinic antagonists) in adults and children  $\geq$  12 years old for at least 3 months fails to maintain adequate control
  - f. History of treatment failure, intolerance or contraindication to at least a 4 month trial of Fasenna<sup>®</sup> or Nucala<sup>®</sup>
  - g. History of treatment failure, intolerance or contraindication to at least a 4 month trial of Dupixent<sup>®</sup>
  - h. Not to be used in combination with other biologics or targeted DMARDs immunosuppressants for the same indication
  - i. Trial and failure, contraindication, OR intolerance to the preferred products as listed in BCBSM/BCN's utilization management medical drug list
- B. Quantity Limitations, Authorization Period and Renewal Criteria
  - a. Quantity Limits: Align with FDA recommended dosing
  - b. Authorization Period: One year at a time.
  - c. Renewal Criteria: Clinical documentation must be provided to confirm that current criteria are met and that the medication is providing clinical benefit

\*\*\*Note: Coverage and approval duration may differ for Medicare Part B members based on any applicable criteria outlined in Local Coverage Determinations (LCD) or National Coverage Determinations (NCD) as determined by Center for Medicare and Medicaid Services (CMS). See the CMS website at <http://www.cms.hhs.gov/>. Determination of coverage of Part B drugs is based on medically accepted indications which have supported citations included or approved for inclusion determined by CMS approved compendia.

### Background Information:

- Cinqair is an interleukin-5 (IL5) antagonist monoclonal antibody (IgG4, kappa) indicated for add-on maintenance treatment of patients with severe asthma aged 12 years and older, and with an eosinophilic phenotype.
- Eosinophilic asthma is a sub phenotype of severe asthma characterized by elevated sputum and blood eosinophil levels as well as increased asthma severity, atopy, late-onset disease, and steroid refractoriness.
- Severe asthma requires treatment with high dose inhaled corticosteroids (ICS) plus a second controller (and/or systemic corticosteroids) to prevent it from becoming uncontrolled or which remains uncontrolled despite therapy. Add-on treatment for severe asthma includes LAMA, leukotriene receptor antagonist (LTRA), low dose azithromycin (adults) and biologic agents for severe allergic or severe type 2 asthma. Type 2 inflammation is found in majority of the of people with severe asthma and characterized by production of cytokines such as interleukin. Anti-IL5 monoclonal antibodies (Cinqair, Nucala, and Fasenra) specifically target the formation of eosinophils and deplete blood eosinophil levels.
- Add-on treatments for severe asthma include LAMAs, LTRA, low dose azithromycin (adults), and biologic agents for severe allergic or severe type 2 asthma. Type 2 inflammation is found in a majority of people with severe asthma and is characterized by the production of cytokines such as interleukin (IL). The Global Initiative for Asthma (GINA) 2022 guidelines have the following recommendations for add-on biologic therapy for severe asthma:
  - Add-on anti-immunoglobulin E (anti-IgE) (omalizumab) treatment: for patients aged  $\geq 6$  years with moderate or severe allergic asthma that is uncontrolled on Step 4–5 treatment (Evidence A).
  - Add-on anti-interleukin-5/5R treatment (subcutaneous mepolizumab for patients aged  $\geq 6$  years; intravenous reslizumab for ages  $\geq 18$  years or subcutaneous benralizumab for ages  $\geq 12$  years), with severe eosinophilic asthma that is uncontrolled on Step 4–5 treatment. Efficacy data for mepolizumab in children 6–11 years are limited to one very small open label uncontrolled study.
  - Add-on anti-interleukin-4R $\alpha$  treatment (subcutaneous dupilumab) for patients aged  $\geq 6$  years with severe eosinophilic/Type 2 asthma, or for adults or adolescents requiring treatment with maintenance oral corticosteroids.
  - Add-on anti-thymic stromal lymphopoietin (anti-TSLP) (subcutaneous tezepelumab): for patients aged  $\geq 12$  years with severe asthma (Evidence A).
- Per the GINA 2023 guidelines, a trial of at least 4 months of an add-on biologic therapy is recommended before assessing response.
- A peripheral blood eosinophil count is an indirect way to estimate airway inflammation. A blood eosinophil count  $\geq 300$  cells/microliter may help to predict asthmatics who are at increased risk for exacerbations in the next year. Furthermore, a count-response relation exists between blood eosinophil counts and asthma-related outcomes. The European Respiratory Society/American Thoracic Society guidelines from 2020 suggest that treatment of severe asthma be guided by clinical criteria and biomarkers such as blood eosinophil levels or fractional exhaled nitric oxide (FeNO), rather than by clinical criteria alone. In addition, it also suggests that a blood eosinophil count cut-off point of

≥ 150 cells/microliter can be used to guide anti-IL5 initiation in adult patients with severe asthma and a history of prior asthma exacerbations.

- Efficacy of Cinqair was evaluated versus placebo in four randomized, double-blind placebo-controlled trials of up to 52 weeks in a total of 981 patients.
  - In Studies I and II, the primary endpoint was the frequency of clinically significant exacerbations of asthma. Patients receiving Cinqair 3 mg/kg once every 4 weeks experienced significantly fewer exacerbations in comparison to patients receiving placebo.
  - Exacerbations requiring the use of a systemic corticosteroid as well as exacerbations resulting in hospitalization or an emergency room visit were each reduced with Cinqair 3 mg/kg.
  - In Studies III and IV, the primary endpoint was forced expiratory volume in one second (FEV1). Patients receiving Cinqair showed a significant improvement in lung function through changes in FEV1.
- Review response to biologic therapy after 3-4 months of treatment. If the patient had a good response, the need for each medication should re-evaluated, but do not completely stop inhaled therapy. Consider gradually decreasing or stopping oral steroids first.

#### References:

1. Cinqair® [package insert]. Frazer, PA: Teva Pharmaceutical Industries Ltd; February 2020.
2. Bleecker ER, Fitzgerald JM, Chanez P, et al. Efficacy and safety of Fasenra for patients with severe asthma uncontrolled with high-dosage inhaled corticosteroids and long-acting β<sub>2</sub>-agonists (SIROCCO): a randomized, multicenter, placebo-controlled phase 3 trial. *Lancet*. 2016;388:2115-2127.
3. FitzGerald JM, Bleecker ER, Nair P, et al. Benralizumab, an anti-interleukin-5 receptor α monoclonal antibody, as add-on treatment for patients with severe, uncontrolled, eosinophilic asthma (CALIMA): a randomized, double-blind, placebo-controlled phase 3 trial. *Lancet*. 2016;388:2128-2141.
4. Global Initiative for Asthma. Global Strategy for Asthma Management and Prevention, 2023. Available from: [www.ginasthma.org](http://www.ginasthma.org).
5. Holguin F, Cardet JC, Chung KF, et al. Management of severe asthma: a European Respiratory Society/American Thoracic Society guideline. *Eur Respir J* 2020; 55.

**Table 1: Comparative cumulative daily dosing of inhaled corticosteroids (mcg/day)**

Inhaled Corticosteroid	Ages 12 and Up			Ages 6-11		
	Low Dose	Medium Dose	High Dose	Low Dose	Medium Dose	High Dose
Beclomethasone dipropionate HFA	100 – 200	>200 – 400	>400	50 – 100	>100 – 200	>200
Budesonide DPI	200 – 400	>400 – 800	>800	100 – 200	>200 – 400	>400
Budesonide nebulas	NA	NA	NA	250 – 500	>500 – 1,000	>1,000
Ciclesonide HFA	80 – 160	>160 – 320	>320	80	>80 – 160	>160
Fluticasone furoate DPI	100	NA	200	NA	NA	NA
Fluticasone propionate DPI	100 – 250	>250 – 500	>500	100 – 200	>200 – 400	>400
Fluticasone propionate HFA	100 – 250	>250 – 500	>500	100 – 200	>200 – 500	>500
Mometasone furoate	110 – 220	>220 – 440	>440	110	≥220 - <440	≥440
Triamcinolone acetonide	400 – 1,000	>1,000 – 2,000	>2,000	400 – 800	>800 – 1,200	>1,200

Policy History		
#	Date	Change Description
2.8	Effective Date: 10/03/2024	Changed the “Cannot be used in combination with other biologics for asthma” criteria to “Not to be used in combination with other biologics or targeted DMARDs for the same indication”
2.7	Effective Date: 04/11/2024	Annual review of criteria was performed, no changes were made
2.6	Effective Date: 04/06/2023	Updated to require a 4 month trial of guideline supported pharmacy benefit alternatives
2.5	Effective Date: 10/06/2022	Annual review of criteria was performed, no changes were made
2.4	Effective Date: 10/07/2021	Updated LABA and LAMA requirement to LABA or LAMA
2.3	Effective Date: 06/10/2021	Criteria document created and criteria aligned between all biologic asthma agents. The criteria for asthma was previously part of the Biologics for Asthma Policy which will be retired after this P&T.
2.2	Effective Date: 08/13/2020	Criteria updated for Fasentra
2.1	Effective Date: 4/16/2020	Criteria update for step therapy to reference dosing chart for inhaled corticosteroids.
2.0	Effective Date: 12/05/2019	Updated policy criteria to include Fasentra self-administered product
1.9	Effective Date: 11/7/2019	Criteria update to authorization period and include FDA approved age
1.8	Effective Date: 08/15/2019	Updated criteria to account for new self-injectable Nucala formulation
1.7	Effective Date: 02/14/2019	Criteria update

This policy and any information contained herein is the property of Blue Cross Blue Shield of Michigan and its subsidiaries, is strictly confidential, and its use is intended for the P&T committee, its members and BCBSM employees for the purpose of coverage determinations.

1.6	Effective Date: 11/01/2018	Update Criteria										
1.5	Effective Date: 02/12/2018	UM medical management system update for MAPPO and BCNA <table border="1" data-bbox="483 268 1365 478"> <thead> <tr> <th>Line of Business</th> <th>PA Required in Medical Management System (Yes/No)</th> </tr> </thead> <tbody> <tr> <td>BCBS</td> <td>Yes</td> </tr> <tr> <td>BCN</td> <td>Yes</td> </tr> <tr> <td>MAPPO</td> <td>Yes</td> </tr> <tr> <td>BCNA</td> <td>Yes</td> </tr> </tbody> </table>	Line of Business	PA Required in Medical Management System (Yes/No)	BCBS	Yes	BCN	Yes	MAPPO	Yes	BCNA	Yes
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BCBS	Yes											
BCN	Yes											
MAPPO	Yes											
BCNA	Yes											
1.4	Effective Date: 02/08/2018	Annual Review of Medical Policy										
1.3	Effective Date: 02/09/2017	Update Criteria										
1.2	Effective Date: 08/11/2016	New Criteria										
1.1	Effective Date: 06/01/2016	UM medical management system update for BCBSM and BCN <table border="1" data-bbox="483 762 1365 972"> <thead> <tr> <th>Line of Business</th> <th>PA Required in Medical Management System (Yes/No)</th> </tr> </thead> <tbody> <tr> <td>BCBS</td> <td>Yes</td> </tr> <tr> <td>BCN</td> <td>Yes</td> </tr> <tr> <td>MAPPO</td> <td>No</td> </tr> <tr> <td>BCNA</td> <td>No</td> </tr> </tbody> </table>	Line of Business	PA Required in Medical Management System (Yes/No)	BCBS	Yes	BCN	Yes	MAPPO	No	BCNA	No
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BCBS	Yes											
BCN	Yes											
MAPPO	No											
BCNA	No											
1.0	Effective Date: 02/11/2016	Preliminary Criteria										

\* The prescribing information for a drug is subject to change. To ensure you are reading the most current information it is advised that you reference the most updated prescribing information by visiting the drug or manufacturer website or <http://dailymed.nlm.nih.gov/dailymed/index.cfm>

**Blue Cross Blue Shield/Blue Care Network of Michigan**  
**Medication Authorization Request Form**  
**Cinqair® (reslizumab) HCPCS CODE: J2786**



This form is to be used by participating physicians to obtain coverage for Cinqair®. For commercial members only, please complete this form and submit via fax to 1-877-325-5979. If you have any questions regarding this process, please contact BCBSM Provider Relations and Servicing or the Medical Drug Helpdesk at 1-800-437-3803 for assistance.

PATIENT INFORMATION	PHYSICIAN INFORMATION
<b>Name</b>	<b>Name</b>
<b>ID Number</b>	<b>Specialty</b>
<b>D.O.B.</b> <span style="float:right"><input type="checkbox"/> Male <input type="checkbox"/> Female</span>	<b>Address</b>
<b>Weight (kg):</b> <span style="float:right">Date recorded: _____</span>	
<b>Diagnosis</b>	<b>City /State/Zip</b>
<b>Drug Name</b> <span style="float:right"><input type="checkbox"/> Cinqair</span>	<b>Phone/Fax: P: (     )     -     F: (     )     -</b>
<b>Dose and Quantity</b>	<b>NPI</b>
<b>Directions</b>	<b>Contact Person</b>
<b>Date of Service(s)</b>	<b>Contact Person Phone / Ext.</b>

**STEP 1: DISEASE STATE INFORMATION**

- Is this request for:  Initiation  Continuation **Date patient started therapy:** \_\_\_\_\_
- Site of administration?  Provider office/Home infusion  Other: \_\_\_\_\_  
 Hospital outpatient facility (go to #3) **Reason for Hospital Outpatient administration:** \_\_\_\_\_
- Please specify location of administration if hospital outpatient infusion:** \_\_\_\_\_
- Please provide the NPI number for the place of administration:** \_\_\_\_\_
- Initiation AND Continuation of therapy:**
  - Please check the patient's diagnosis:  Severe eosinophilic asthma (EA)  Other: \_\_\_\_\_
  - What is the patient's blood eosinophil level at the initiation of therapy in cells/microliter? \_\_\_\_\_ Date of Result: \_\_\_\_\_
  - Which treatment(s) did not adequately control the patient's EA after a trial of at least 3 months?
    - Systemic corticosteroid: \_\_\_\_\_ Date: Start: \_\_\_\_\_ End: \_\_\_\_\_
    - High dose inhaled corticosteroids: \_\_\_\_\_ Date: Start: \_\_\_\_\_ End: \_\_\_\_\_
    - Long acting beta2-agonist: \_\_\_\_\_ Date: Start: \_\_\_\_\_ End: \_\_\_\_\_
    - Leukotriene receptor antagonist: \_\_\_\_\_ Date: Start: \_\_\_\_\_ End: \_\_\_\_\_
    - Combination asthma inhaler with a HIGH dose corticosteroid and a long acting beta agonist: \_\_\_\_\_ Date: Start: \_\_\_\_\_ End: \_\_\_\_\_
    - Combination asthma inhaler with a MEDIUM dose corticosteroid and a long acting beta agonist: \_\_\_\_\_ Date: Start: \_\_\_\_\_ End: \_\_\_\_\_
    - Long acting muscarinic antagonist (LAMA): \_\_\_\_\_ Date: Start: \_\_\_\_\_ End: \_\_\_\_\_
    - Other: \_\_\_\_\_ Date: Start: \_\_\_\_\_ End: \_\_\_\_\_
  - Please select the preferred product(s) the patient has tried for at least 4 months and experienced treatment failure, intolerance, or contraindication the requested indication.
 Nucala  Fasenna  Dupixent  Tezspire  Other: \_\_\_\_\_
  - Is the patient currently receiving and will continue to receive a standard of care regimen for their diagnosis with Cinqair?
 Yes  No **Comment:** \_\_\_\_\_
  - Will the patient be using Cinqair in combination with other biologic asthma agents (for example: Xolair, Nucala, Fasenna, or Tezspire)?
 Yes  No **Comment:** \_\_\_\_\_
- Continuation request:** (please answer above questions as well): **Cinqair start date:** \_\_\_\_\_
  - Have the patient's signs and symptoms improved with Cinqair?
 Yes  No, **Comment:** \_\_\_\_\_  Other: \_\_\_\_\_

Please add any other supporting medical information necessary for our review

**Coverage will not be provided if the prescribing physician's signature and date are not reflected on this document.**

Request for expedited review: I certify that applying the standard review time frame may seriously jeopardize the life or health of the member or the member's ability to regain maximum function

<b>Physician's Name</b>	<b>Physician Signature</b>	<b>Date</b>
<b>Step 2 Checklist</b>	<input type="checkbox"/> Form Completely Filled Out <input type="checkbox"/> Attach Chart Notes	<input type="checkbox"/> Attach Diagnostic Tests
<b>Step 3 Submit</b>	<b>By Fax: BCBSM Specialty Pharmacy Mailbox 1-877-325-5979</b>	<b>By Mail: BCBSM Specialty Pharmacy Program P.O. Box 312320, Detroit, MI 48231-2320</b>