| Reslizumab (Cinqair®) | Place of Service<br>Home Infusion Administration<br>Infusion Center Administration<br>Office Administration<br>Outpatient Facility Administration*<br>[*Prior authorization required – see section (1)]<br><br>HCPCS: J2786 per 1 mg |
|---|---|

Condition listed in policy *(see criteria for details)*

- Severe eosinophilic asthma

**AHFS therapeutic class:** Interleukin Antagonists

**Mechanism of action**: Interleukin-5 antagonist monoclonal antibody

## (1) Special Instructions and Pertinent Information

**Covered under the medical benefit,** please submit clinical information for prior authorization review.

## **CRITERIA FOR HOSPITAL OUTPATIENT FACILITY ADMINISTRATION **

*AAAAI Guidelines 2011, MCG™ Care Guidelines, 19th edition, 2015*

Members with the following plans: **PPO, Direct Contract HMO, and when applicable, Medi-Cal, ASO/Shared Advantage/HMO (non-direct contract)** may be required to have their medication administered at a preferred site of service, including the home, a physician's office, or an independent infusion center not associated with a hospital.
For members that cannot receive infusions in the preferred home or ambulatory setting AND meet one of the following criteria points, drug administration may be performed at a hospital outpatient facility infusion center.

ADMINISTRATION OF CINQAIR IN THE HOSPITAL OUTPATIENT FACILITY SITE OF CARE REQUIRES ONE OF THE FOLLOWING: (*Supporting Documentation must be submitted)*

1. **Patient is receiving their first infusion of Cinqair or is being re-initiated on Cinqair after at least 6 months off therapy.** *Subsequent doses will require medical necessity for continued use in the hospital outpatient facility site of care.*

**Or**

**Additional clinical monitoring is required during administration as evidenced by one of the following:**

2. **Patient has experienced a previous severe adverse event on Cinqair based on documentation submitted.**

3. **Patient continues to experience moderate to severe adverse events on Cinqair based on documentation submitted, despite receiving premedication such as acetaminophen, steroids, diphenhydramine, fluids, etc.**

4. **Patient is clinically unstable based on documentation submitted.**

5. **Patient is physically or cognitively unstable based on documentation submitted.**

**(2) Prior Authorization/Medical Review is required for the following condition(s)**

**All requests for Cinqair® (reslizumab) must be sent for clinical review and receive authorization prior to drug administration or claim payment.**

Severe eosinophilic asthma

1. Prescribed by or in consultation with a pulmonologist, allergist, or immunologist, **AND**
2. Patient is at least 18 years of age, **AND**
3. Eosinophil blood count of ≥ 400 cells/µL within last 3 to 4 weeks, **AND**
4. Asthma symptoms remain uncontrolled despite 3 months of treatment with a high-dose inhaled corticosteroid in combination with long-acting beta agonist (LABA) or leukotriene receptor antagonists (LTRA), **AND**
5. Meets ONE of the following within the past year:
    a. One or more acute asthma-related ED visit(s), or
    b. One or more acute inpatient visits where asthma was the principal diagnosis, or
    c. Use of chronic systemic steroids due to severe asthma OR two or more acute asthma exacerbations requiring oral systemic steroids

    **AND**
6. Will not be used in combination with another biologic medication indicated for asthma treatment (e.g., Dupixent, Fasenra, Nucala, or Xolair)

**Covered Dose**
Up to 3 mg/kg IV every 4 weeks

**Coverage Period**
Initial Authorization: 6 months

Reauthorization: Indefinite if the following criteria is met
1. Patient is not receiving Cinqair in combination with another biologic medication indicated for asthma treatment, **AND**
2. Provider attestation that asthma symptoms have improved and/or controlled while on Cinqair

**ICD-10:**
J45.20-J45.998

**(3) The following condition(s) DO NOT require Prior Authorization/Preservice**

**All requests for Cinqair® (reslizumab) must be sent for clinical review and receive authorization prior to drug administration or claim payment.**

**(4) This Medication is NOT medically necessary for the following condition(s)**

Coverage for a Non-FDA approved indication, requires that criteria outlined in Health and Safety Code § 1367.21, including objective evidence of efficacy and safety are met for the proposed indication.

Please refer to the Provider Manual and User Guide for more information.

**(5) Additional Information**

How Supplied:
100 mg (10 mg/mL, single-use vial)

## (6) References


- AHFS®. Available by subscription at http://www.lexi.com
- Cinqair® (reslizumab) [Prescribing Information]. West Chester, PA: Teva Pharmaceuticals; 2/2020.
- DrugDex®. Available by subscription at http://www.micromedexsolutions.com/home/dispatch
- Global Initiative for Asthma. Global Strategy for Asthma Management and Prevention (2022 Update). Available from: www.ginasthma.org.


## (7) Policy Update

Date of last review: 1Q2023
Date of next review: 1Q2024
Changes from previous policy version:

- No clinical change to policy following routine annual review.

*BSC Drug Coverage Criteria to Determine Medical Necessity*
*Reviewed by P&T Committee*