

PRIOR AUTHORIZATION POLICY

POLICY: Immunologicals – Cinqair Prior Authorization Policy

- Cinqair® (reslizumab intravenous infusion – Teva Respiratory)

REVIEW DATE: 03/16/2022; selected revision 07/20/2022

OVERVIEW

Cinqair, an interleukin-5 antagonist monoclonal antibody, is indicated for **severe asthma** as add-on maintenance treatment of patients ≥ 18 years of age who have an eosinophilic phenotype.¹ Limitations of Use: Cinqair is not indicated for the treatment of other eosinophilic conditions or for the relief of acute bronchospasm/status asthmaticus.

Clinical Efficacy

The Cinqair pivotal studies included adult and adolescent patients with moderate to severe asthma who had baseline blood eosinophil levels ≥ 400 cells/microliter despite therapy.²⁻⁴ In one study that did not require patients to have elevated eosinophils at baseline, clinical benefit in regard to forced expiratory volume in 1 second (FEV₁) was not statistically significant with Cinqair vs. placebo. However, a significant improvement was observed in a subgroup of patients with baseline eosinophil levels ≥ 400 cells/microliter.

Guidelines

The Global Initiative for Asthma Global Strategy for Asthma Management and Prevention (2022) proposes a step-wise approach to asthma treatment.⁵ Cinqair is listed as an option for add-on therapy in patients ≥ 18 years of age with difficult-to-treat, severe eosinophilic asthma (i.e., asthma that cannot be managed by therapy with an inhaled corticosteroid [ICS]/long-acting beta₂-agonist [LABA] combination with or without an additional controller). Higher blood eosinophil levels, more exacerbations in the previous year, adult-onset asthma, nasal polyposis, a maintenance corticosteroid requirement at baseline, and low lung function may predict a good asthma response to Cinqair.

According to the European Respiratory Society/American Thoracic Society guidelines (2014; updated in 2020), severe asthma is defined as asthma which requires treatment with a high-dose ICS in addition to a second controller medication (and/or systemic corticosteroids) to prevent it from becoming uncontrolled, or asthma which remains uncontrolled despite this therapy.^{6,7} Uncontrolled asthma is defined as asthma that worsens upon tapering of high-dose ICS or systemic corticosteroids or asthma that meets one of the following four criteria:

- 1) Poor symptom control: Asthma Control Questionnaire consistently ≥ 1.5 or Asthma Control Test < 20 ;
- 2) Frequent severe exacerbations: two or more bursts of systemic corticosteroids in the previous year;
- 3) Serious exacerbations: at least one hospitalization, intensive care unit stay, or mechanical ventilation in the previous year;
- 4) Airflow limitation: FEV₁ $< 80\%$ predicted after appropriate bronchodilator withholding.

POLICY STATEMENT

Prior Authorization is recommended for prescription benefit coverage of Cinqair. All approvals are provided for the duration noted below. In cases where the approval is authorized in months, 1 month is equal to 30 days. Because of the specialized skills required for evaluation and diagnosis of patients treated with Cinqair as well as the monitoring required for adverse events and long-term efficacy, initial approval requires Cinqair to be prescribed by or in consultation with a physician who specializes in the condition being treated.

Automation: None.

RECOMMENDED AUTHORIZATION CRITERIA

Coverage of Cinqair is recommended in those who meet the following criteria:

FDA-Approved Indication

- 1. Asthma.** Approve Cinqair for the duration noted if the patient meets one of the following conditions (A or B):
 - A) Initial Therapy.** Approve for 6 months if the patient meets the following criteria (i, ii, iii, iv, and v):
 - i.** Patient is ≥ 18 years of age; AND
 - ii.** Patient has a blood eosinophil count ≥ 400 cells per microliter within the previous 4 weeks or within 4 weeks prior to treatment with Cinqair or another monoclonal antibody therapy that may lower blood eosinophil levels; AND
Note: Examples of monoclonal antibody therapies that may lower blood eosinophil levels include Cinqair, Adbry (tralokinumab-ldrm subcutaneous injection), Dupixent (dupilumab subcutaneous injection), Fasentra (benralizumab subcutaneous injection), Nucala (mepolizumab subcutaneous injection), Tezspire (tezepelumab-ekko subcutaneous injection), and Xolair (omalizumab subcutaneous injection).
 - iii.** Patient has received at least 3 consecutive months of combination therapy with BOTH of the following (a and b):
 - a)** An inhaled corticosteroid; AND
 - b)** At least one additional asthma controller or asthma maintenance medication; AND
Note: Examples of additional asthma controller or asthma maintenance medications are inhaled long-acting beta₂-agonists, inhaled long-acting muscarinic antagonists, leukotriene receptor antagonists, and monoclonal antibody therapies (e.g., Cinqair, Dupixent, Fasentra, Nucala, Tezspire, Xolair). Use of a combination inhaler containing both an inhaled corticosteroid and additional asthma controller/maintenance medication(s) would fulfil the requirement for both criteria a and b.
 - iv.** Patient has asthma that is uncontrolled or was uncontrolled at baseline as defined by ONE of the following (a, b, c, d, or e):
Note: “Baseline” is defined as prior to receiving Cinqair or another monoclonal antibody therapy for asthma. Examples of monoclonal antibody therapies for asthma include Cinqair, Dupixent, Fasentra, Nucala, Tezspire, and Xolair.
 - a)** Patient experienced two or more asthma exacerbations requiring treatment with systemic corticosteroids in the previous year; OR
 - b)** Patient experienced one or more asthma exacerbation(s) requiring a hospitalization, an emergency department visit, or an urgent care visit in the previous year; OR
 - c)** Patient has a forced expiratory volume in 1 second (FEV₁) < 80% predicted; OR
 - d)** Patient has an FEV₁/forced vital capacity (FVC) < 0.80; OR

- e) Patient has asthma that worsens upon tapering of oral (systemic) corticosteroid therapy; AND
 - v. The medication is prescribed by or in consultation with an allergist, immunologist, or pulmonologist.
- B) Patient is Currently Receiving Cinqair.** Approve for 1 year if the patient meets the following criteria (i, ii, and iii):
- i. Patient has already received at least 6 months of therapy with Cinqair; AND
Note: A patient who has received < 6 months of therapy or who is restarting therapy with Cinqair should be considered under criterion 1A (Asthma, Initial Therapy).
 - ii. Patient continues to receive therapy with one inhaled corticosteroid or one inhaled corticosteroid-containing combination; AND
 - iii. Patient has responded to therapy as determined by the prescriber.
Note: Examples of a response to Cinqair therapy are decreased asthma exacerbations; decreased asthma symptoms; decreased hospitalizations, emergency department, urgent care, or medical clinic visits due to asthma; and decreased requirement for oral corticosteroid therapy.

CONDITIONS NOT RECOMMENDED FOR APPROVAL

Coverage of Cinqair is not recommended in the following situations:

1. **Concurrent use with another Monoclonal Antibody Therapy.** The efficacy and safety of Cinqair used in combination with other monoclonal antibody therapies (e.g., Adbry, Dupixent, Fasenna, Nucala, Tezspire, and Xolair) have not been established.
2. **Eosinophilic Esophagitis or Eosinophilic Gastroenteritis.** Cinqair is not indicated for the treatment of eosinophilic conditions other than asthma.¹ In addition to a small pilot study, one randomized, double-blind, placebo-controlled study (n =226) evaluated the efficacy of Cinqair in pediatric and adolescent patients with eosinophilic esophagitis.^{8,9} In this study, patients were randomly assigned to receive Cinqair IV at varying doses for 12 weeks. At Week 15, peak esophageal eosinophil counts were reduced from baseline and all reductions with Cinqair were significant compared with placebo. Improvements in physician’s global assessment scores were also observed in all groups (including placebo), but the difference between Cinqair and placebo was not statistically significant. Guidelines for the management of eosinophilic esophagitis from the American Gastroenterological Association and the Joint Task Force on Allergy-Immunology Practice Parameters (2020) only recommend using anti-interleukin-5 therapies in the context of a clinical trial.¹⁰ Additional, well-controlled trials are needed to determine the role of Cinqair in the treatment of eosinophilic esophagitis and eosinophilic gastroenteritis.
3. **Hyper eosinophilic Syndrome.** Cinqair is not indicated for the treatment of eosinophilic conditions other than asthma.¹ One very small pilot study (n = 4) evaluated the safety and efficacy of Cinqair in patients with hyper eosinophilic syndrome who were refractory to or intolerant of treatment with conventional therapy.¹¹ A single dose of Cinqair resulted in a response in two of four patients. In the two responders, blood eosinophil counts dropped to within the normal range within 48 hours of the Cinqair infusion and this was accompanied by an improvement in clinical signs and symptoms. The World Health Organization-defined eosinophilic disorders update on diagnosis, risk stratification, and management (2022) notes that Cinqair has not been evaluated extensively for the treatment of hyper eosinophilic syndrome.¹² Corticosteroids remain first-line therapy for hyper eosinophilic syndrome. Additional, well-controlled trials are needed to determine the role of Cinqair in the treatment of hyper eosinophilic syndrome.

4. **Nasal Polyps.** Cinqair is not indicated for the treatment of nasal polyps.¹ One double-blind, placebo-controlled, randomized safety and pharmacokinetic study (n = 24) evaluated the use of Cinqair in patients with nasal polyps.¹³ Patients received a single infusion of either Cinqair 3 mg/kg, Cinqair 1 mg/kg, or placebo. It was reported that blood eosinophil counts and concentrations of eosinophil cation protein were reduced for up to 8 weeks following the Cinqair infusion. Nasal polyp scores improved for approximately 4 weeks in one-half of patients receiving active treatment. Additionally, a pooled subgroup analysis from the two pivotal Cinqair asthma exacerbation trials found that in patients with inadequately controlled asthma and chronic sinusitis with nasal polyps (n = 150) Cinqair demonstrated enhanced efficacy. Patients in this subgroup experienced an 83% reduction the clinical asthma exacerbation rate with Cinqair vs. placebo.¹⁴ The magnitude of this reduction was greater than that observed with the overall study population. A Practice Parameter on the Diagnosis and Management of Rhinosinusitis (2014) and a Practice Parameter for the Management of Rhinitis (2020) from the Joint Task Force on Allergy-Immunology Practice Parameters, note that Cinqair has shown benefit in the treatment of patients with chronic rhinosinusitis with nasal polyps.¹⁵⁻¹⁸ However, it is noted that Cinqair is not approved for this use. A Clinical Practice Guideline update on Adult Sinusitis from the American Academy of Otolaryngology (2015) address the management of nasal polyps, but do not address Cinqair.¹⁹ Additional, well-designed, controlled trials are needed to determine the role of Cinqair in the treatment of patients with nasal polyps who do not have asthma.
5. Coverage is not recommended for circumstances not listed in the Recommended Authorization Criteria. Criteria will be updated as new published data are available.

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