Pharmacy Medical Policy
Injectable Asthma Medications

Table of Contents
- Policy: Commercial
- Policy: Medicare
- Coding Information
- Policy History
- Information Pertaining to All Policies
- References
- Forms

Policy Number: 017
BCBSA Reference Number: None

Related Policies
Dupixent (dupilumab) resides in Medical policy 033
Quality Care Dosing guidelines may apply to the following medications and can be found in Medical Policy #621

Prior Authorization Information

<table>
<thead>
<tr>
<th>☒ Prior Authorization</th>
<th>Pharmacy Operations:</th>
<th>7/1/2023</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Step Therapy</td>
<td>Tel: 1-800-366-7778</td>
<td></td>
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<tr>
<td>☒ Quality Care Dosing</td>
<td>Fax: 1-800-583-6289</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Policy last updated</td>
<td></td>
</tr>
</tbody>
</table>

Pharmacy (Rx) or Medical (MED) benefit coverage

| ☒ Rx | ☒ MED |

Policy applies to Commercial Members:
- Managed Care (HMO and POS),
- PPO and Indemnity
- MEDEX with Rx plan
- Managed Major Medical with Custom BCBSMA Formulary
- Comprehensive Managed Major Medical with Custom BCBSMA Formulary
- Managed Blue for Seniors with Custom BCBSMA Formulary

To request for coverage: Physicians may call, fax, or mail the attached form (Formulary Exception/Prior Authorization form) to the address below.

Blue Cross Blue Shield of Massachusetts
Pharmacy Operations Department
25 Technology Place
Hingham, MA 02043

Individual Consideration: Policy for requests that do not meet clinical criteria of this policy, see section labeled Individual Consideration
Policy
Commercial Members: Managed Care (HMO and POS), PPO, and Indemnity

Note: All requests for outpatient retail pharmacy for indications listed and not listed on the medical policy guidelines may be submitted to BCBSMA Clinical Pharmacy Operations by completing the Prior Authorization Form on the last page of this document.

Cinqair® (reslizumab) is indicated for the add-on maintenance treatment of patients with severe asthma when ALL of the following criteria must be met:
- Patient is ≥ 18 years old, And
- Patient is diagnosed with an eosinophilic phenotype, And
- CINQAIR is NOT indicated for treatment of other eosinophilic conditions, And
- CINQAIR is NOT indicated for the relief of acute bronchospasm or status asthmaticus.

Fasenra™ (benralizumab) is indicated for the add-on maintenance treatment of patients with severe asthma when ALL of the following criteria must be met:
- Patient is ≥ 12 years old, And
- Patient is diagnosed with an eosinophilic phenotype, And
- Fasenra™ is NOT indicated for treatment of other eosinophilic conditions, And
- Fasenra™ is NOT indicated for the relief of acute bronchospasm or status asthmaticus.

Nucala® (mepolizumab) may be covered when ALL of the following criteria must be met:
- add-on maintenance treatment of patients with severe asthma, And
- Patient is ≥ 6 years old, And
- Patient is diagnosed with an eosinophilic phenotype
  Or
  • An adult patient is diagnosed with an eosinophilic granulomatosis with polyangiitis (EGPA).
  Or
  • For adult and pediatric patients aged 12 years and older with hypereosinophilic syndrome (HES) for ≥6 months without an identifiable non-hematologic secondary cause.
  Or
  • For the add-on maintenance treatment of chronic rhinosinusitis with nasal polyps (CRSwNP) in adult patients 18 years of age and older with inadequate response to nasal corticosteroids.

Tezspire™ (tezepelumab) is indicated for the add-on maintenance treatment of patients with severe asthma when ALL of the following criteria must be met:
- Patient is ≥ 12 years old, AND
- Patient is diagnosed with severe asthma, AND
- Tezspire™ is NOT indicated for the relief of acute bronchospasm or status asthmaticus.

Xolair™ (omalizumab), a recombinant humanized monoclonal anti-immunoglobulin E (IgE) antibody, may be covered for allergic mediated moderate-to-severe asthma caused by perennial aeroallergens, and in accordance with the FDA approved criteria. ALL of the following criteria must be met:
- Patient is ≥ 6 years old
- Asthma symptoms are not adequately controlled by > 3 months of continuous therapy of high dose inhaled steroids or oral steroids
- Patient has a positive skin test or in vitro testing for one or more perennial aeroallergen
- For pediatric patients between 6 years old and 12 years old recent IgE levels are within the range of 30 to 1300 IU/ml (“recent” is defined as any time prior to treatment but within 6 months)
- For Patients 12 years and older recent IgE levels are within the range of 30 to 700 IU/ml (“recent” is defined as any time prior to treatment but within 6 months)
Xolair™*^ (omalizumab) also may be covered if ALL of the following are met:
- Patient is ≥ 12 years old
- Patient has a diagnosis of chronic idiopathic urticaria (CIU) with at least a 6 week history of urticaria and presence of hives
- Documented failure, contraindication, or intolerance to a four-week trial of one second-generation non-sedating histamine receptor type 1 (H1) antihistamine
  - AND
- Documented failure, contraindication, or intolerance to at least a two-week trial of ANY ONE of the following medications:
  - Leukotriene receptor antagonist OR
  - Histamine H2-receptor antagonist OR
  - First-generation (sedating) H1 antihistamine OR
  - Substitution to a different second-generation non-sedating H1 antihistamine

Xolair™*^ (omalizumab) also may be covered if ALL of the following are met:
- Patient is ≥ 18 years old
- is indicated for treatment of nasal polyps
- Concurrent therapy with nasal corticosteroids

Xolair™*^ (omalizumab) is not covered except for the condition listed above.

*^ - This medication is Part of the Med UM Program.

** - This Drug is part of Medications covered only under the pharmacy benefit only program. This program does not apply when the medication is administered: in the emergency room, as an inpatient, at a surgical day care facility, in an ambulatory surgery-center, or through home infusion therapy or dialysis. For a small group of self-insured clients, the drug is also part of the Med UM program.

CPT Codes / HCPCS Codes / ICD Codes
Inclusion or exclusion of a code does not constitute or imply member coverage or provider reimbursement. Please refer to the member’s contract benefits in effect at the time of service to determine coverage or non-coverage as it applies to an individual member.

Providers should report all services using the most up-to-date industry-standard procedure, revenue, and diagnosis codes, including modifiers where applicable.

The following codes are included below for informational purposes only; this is not an all-inclusive list.

The above medical necessity criteria MUST be met for the following codes to be covered for Commercial Members: Managed Care (HMO and POS), PPO, and Indemnity:

### HCPCS Codes

<table>
<thead>
<tr>
<th>HCPCS codes:</th>
<th>Code Description</th>
</tr>
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<tbody>
<tr>
<td>J0517</td>
<td>Injection, benralizumab, 1 mg</td>
</tr>
<tr>
<td>J2182</td>
<td>Injection, mepolizumab, 1 mg (Nucala®)</td>
</tr>
<tr>
<td>J2357</td>
<td>Injection, omalizumab, 5 mg (Xolair™)</td>
</tr>
<tr>
<td>J2786</td>
<td>Injection, reslizumab, 1 mg (Cinqair®)</td>
</tr>
</tbody>
</table>

### ICD-10 Diagnosis Codes

| ICD-10-CM Diagnosis codes: | Code Description |
J45.40 Moderate persistent asthma, uncomplicated
J45.41 Moderate persistent asthma with (acute) exacerbation
J45.42 Moderate persistent asthma with status asthmaticus
J45.50 Severe persistent asthma, uncomplicated
J45.51 Severe persistent asthma with (acute) exacerbation
J45.52 Severe persistent asthma with status asthmaticus
J45.901 Unspecified asthma with (acute) exacerbation
J45.902 Unspecified asthma with status asthmaticus
J45.909 Unspecified asthma, uncomplicated
J45.991 Cough variant asthma
J45.998 Other asthma

**Individual Consideration**

All our medical policies are written for the majority of people with a given condition. Each policy is based on medical science. For many of our medical policies, each individual’s unique clinical circumstances may be considered in light of current scientific literature. Physicians may send relevant clinical information for individual patients for consideration to:

Blue Cross Blue Shield of Massachusetts
Pharmacy Operations Department
25 Technology Place
Hingham, MA 02043
Tel: 1-800-366-7778
Fax: 1-800-583-6289

**Policy History**

<table>
<thead>
<tr>
<th>Date</th>
<th>Action</th>
</tr>
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<tbody>
<tr>
<td>7/2023</td>
<td>Update to remove specialist requirement for Xolair.</td>
</tr>
<tr>
<td>4/2022</td>
<td>Updated to add Tezspire™ to the policy.</td>
</tr>
<tr>
<td>8/2021</td>
<td>Updated to add New indication for Nucala ®.</td>
</tr>
<tr>
<td>1/2021</td>
<td>Updated to add new indication for Xolair ®.</td>
</tr>
<tr>
<td>10/2020</td>
<td>Updated to add new indication for Nucala ®. Removed deleted codes</td>
</tr>
<tr>
<td>4/2020</td>
<td>Updated criteria for Xolair on CIU diagnosis</td>
</tr>
<tr>
<td>11/2019</td>
<td>Updated age requirements for Nucala ®.</td>
</tr>
<tr>
<td>7/2019</td>
<td>Updated to add CinQair®, Nucala ® and Fasenra™ to the Med UM program.</td>
</tr>
<tr>
<td>1/2019</td>
<td>Clarified coding information.</td>
</tr>
<tr>
<td>4/2018</td>
<td>Clarified coding information.</td>
</tr>
<tr>
<td>2/2018</td>
<td>Updated to include Fasenra™ and a new indication for Nucala ®.</td>
</tr>
<tr>
<td>10/2017</td>
<td>Updated to clarify pediatric IgE levels.</td>
</tr>
<tr>
<td>6/2017</td>
<td>Update address for Pharmacy Operations.</td>
</tr>
<tr>
<td>1/2017</td>
<td>Updated to include New HCPCS/CPT codes.</td>
</tr>
<tr>
<td>10/2016</td>
<td>Updated to include CinQair® and allow all three medications to be billed on both Medical &amp; Pharmacy.</td>
</tr>
<tr>
<td>6/2016</td>
<td>Updated to include Nucala® to Medical Only and changed the Policy Name.</td>
</tr>
<tr>
<td>7/2014</td>
<td>Updated to include ICD-10 and updated with new Indication CIU.</td>
</tr>
<tr>
<td>1/2014</td>
<td>Updated ExpressPAth language.</td>
</tr>
<tr>
<td>3/2012</td>
<td>Reviewed – Medical Policy Group - Allergy, Asthma, Immunology and ENT/Otolaryngology. No changes to policy statements.</td>
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</tbody>
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References

To request prior authorization using the Massachusetts Standard Form for Medication Prior Authorization Requests (eForm), click the link below: