MASSACHUSETTS

Blue Cross Blue Shield of Massachusetts is an Independent Licensee of the Blue Cross and Blue Shield Association

Pharmacy Medical Policy
Injectable Asthma Medications

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Policy Number: 017

BCBSA Reference Number: N/A

Related Policies

- Quality Care Dosing guidelines may apply to the following medications and can be found in Medical Policy #621A.
- Medical Utilization Management (MED UM) & Pharmacy Prior Authorization Policy #033

Prior Authorization Information

Policy	☒ Prior Authorization ☐ Step Therapy ☒ Quantity Limit ☐ Administrative	Reviewing Department	**Pharmacy Operations:** Tel: 1-800-366-7778 Fax: 1-800-583-6289
		Policy Effective Date	**1/2025**
Pharmacy (Rx) or Medical (MED) benefit coverage	☒ Rx ☒ MED	**To request for coverage:** Providers 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 Tel: 1-800-366-7778 Fax: 1-800-583-6289 **Individual Consideration for the atypical patient:** Policy for requests that do not meet clinical criteria of this policy, see section labeled Individual Consideration	
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 **Policy does NOT apply to**: • Medicare Advantage			

Summary

This is a comprehensive policy covering prior authorization and quantity limit requirements for injectable biologic agents used for the treatment of asthma and other related conditions.

Biologics are targeted therapies that yield better outcomes in specific patient types. They target key cells and mediators that drive inflammatory responses in the asthmatic lung. While most biologics use interleukin inhibition (IL-4, IL-5, and IL-13) to reduce eosinophils, Xolair and Tezspire target IgE and TSLP, respectively.

The variability observed in response to therapy with these biologics emphasize the necessity of accurate asthma typing, to facilitate a personalized treatment tailored for patients with high levels of inflammatory targets in the different subtypes of severe asthma**.**

Biologics should only be considered for patients with the following characteristics

Patients in whom:	Who still have:	Despite management with
• Alternative diagnoses have been excluded • Comorbidities have been treated • Trigger factors have been removed (if possible) • Compliance with treatment has been monitored	• poor asthma control • two or more exacerbations per year	• High-intensity asthma treatment • Systemic corticosteroids while maintaining adequate control

Tezspire is the only biologic approved for severe asthma with no phenotype (e.g., eosinophilic, or allergic) or biomarker limitation within its approved label.

Policy

Length of Approval	12 months
Formulary Status	All requests must meet the Prior Authorizations requirement. For all non-covered medications, the member **must** also have had a previous treatment failure with, or contraindication to, **at least two** covered formulary alternatives when available. See section on individual consideration for more information if you require an exception to any of these criteria requirements for an atypical patient.
Member cost share consideration	A higher non-preferred cost share may be applied if an exception request is approved for coverage of a non-preferred or a non-formulary/non-covered drug.

Formulary status/requirements of the medications affected by this policy:

Drug	Formulary Status (BCBSMA Commercial Plan)	Special Consideration
Cinqair ® (reslizumab)	Covered, *PA	
Fasenra ™ (benralizumab)	Covered, PA, *QCD, *MTPB	Covered under the pharmacy benefit only
Nucala ® (mepolizumab)	Covered, PA, MTPB	Covered under the pharmacy benefit only
Tezspire ™ (tezepelumab)	Covered, PA, MTPB	Covered under the pharmacy benefit only
Xolair ™ (omalizumab)	Covered, PA	

PA – Prior Authorization; QCD – Quality Care Dosing (refer to policy #621b); MTPB – Medical to Pharmacy Benefit program

Prior Authorization Criteria

Cinqair ®

Cinqair may be considered **MEDICALLY NECESSARY** and covered when **ALL** of the following criteria are met:

1. A diagnosis of severe asthma; **AND**
2. Used as an add-on maintenance treatment; **AND**
3. Age ≥ 18 years; **AND**

4. Diagnosis of an eosinophilic phenotype, **AND**
5. The drug is prescribed by a board-certified or board-eligible Allergist or Dermatologist, **AND**
6. Documented Dose and Frequency must be submitted and must be within the FDA approved Dosing and Frequency.

NOTE: *Cinqair is* ***NOT*** *indicated for treatment of other eosinophilic conditions or for the relief of acute bronchospasm or status asthmaticus. Coverage requests for these indications are considered* ***NOT MEDICALLY NECESSARY*** *and therefore not covered*

Fasenra ™

Fasenra may be considered **MEDICALLY NECESSARY** and covered when **ALL** of the following criteria are met:

I. Severe Asthma

1. A diagnosis of severe asthma, **AND**
2. Used as an add-on maintenance treatment, **AND**
3. Age ≥ 6 years, **AND**
4. Documented Dose and Frequency must be submitted and must be within the FDA approved Dosing and Frequency, **AND**
5. The drug is prescribed by a board-certified or board-eligible Allergist or Pulmonologist, **AND**
6. Diagnosis of an eosinophilic phenotype.

II. Eosinophilic Granulomatosis with Polyangiitis (EPGA)

a. A diagnosis of eosinophilic granulomatosis with polyangiitis (EGPA); **AND**

b. Age ≥ 18 years, **AND**

c. Documented Dose and Frequency must be submitted and must be within the FDA approved Dosing and Frequency.

NOTE: *Fasenra is* ***NOT*** *indicated for treatment of other eosinophilic conditions or for the relief of acute bronchospasm or status asthmaticus. Coverage requests for these indications are considered* ***NOT MEDICALLY NECESSARY*** *and therefore not covered*

Nucala ®

Nucala may be considered **MEDICALLY NECESSARY** and covered when **ALL** of the following criteria for each corresponding indication are met:

III. Severe Asthma

1. A diagnosis of severe asthma; **AND**
2. Used as an add-on maintenance treatment; **AND**
3. Age ≥ 6 years; **AND**
4. Diagnosis of an eosinophilic phenotype, **AND**
5. The drug is prescribed by a board-certified or board-eligible Allergist or Pulmonologist, **AND**
6. Documented Dose and Frequency must be submitted and must be within the FDA approved Dosing and Frequency.

IV. Eosinophilic Granulomatosis with Polyangiitis (EPGA)

a. A diagnosis of eosinophilic granulomatosis with polyangiitis (EGPA); **AND**
b. Age ≥ 18 years, **AND**
c. Documented Dose and Frequency must be submitted and must be within the FDA approved Dosing and Frequency.

V. Hypereosinophilic Syndrome (HES)

1. A diagnosis of hypereosinophilic syndrome (HES); **AND**
2. Age ≥ 12 years; **AND**
3. No identifiable non-hematologic secondary cause for at least 6 months, **AND**
4. Documented Dose and Frequency must be submitted and must be within the FDA approved Dosing and Frequency.

VI. Chronic Rhinosinusitis with Nasal Polyps (CRSwNP)

1. A diagnosis of chronic rhinosinusitis with nasal polyps (CRSwNP), **AND**
2. Used as an add-on maintenance treatment, **AND**
3. Age ≥ 18 years, **AND**
4. Previous inadequate response to nasal corticosteroids, **AND**
5. Documented Dose and Frequency must be submitted and must be within the FDA approved Dosing and Frequency.

Tezspire ™

Tezspire may be considered **MEDICALLY NECESSARY** and covered when **ALL** of the following criteria are met:

1. A diagnosis of severe asthma, **AND**
2. Used as an add-on maintenance treatment, **AND**
3. Age ≥ 12 years, **AND**
4. The drug is prescribed by a board-certified or board-eligible Allergist or Pulmonologist, **AND**
5. Documented Dose and Frequency must be submitted and must be within the FDA approved Dosing and Frequency.

NOTE: Tezspire is **NOT** indicated for the relief of acute bronchospasm or status asthmaticus. *Coverage requests for this indication is considered **NOT MEDICALLY NECESSARY** and therefore not covered.*

Xolair ™

Xolair may be considered **MEDICALLY NECESSARY** and covered when **ALL** of the following criteria for each corresponding indication are met:

I. Moderate to Severe Asthma

1. A diagnosis of allergic mediated moderate-to-severe asthma caused by perennial aeroallergen, **AND**
2. Age ≥ 6 years, **AND**
3. Asthma symptoms are not adequately controlled by > 3 months of continuous therapy of high dose inhaled steroids or oral steroids, **AND**

4. Positive skin test or in vitro testing for one or more perennial aeroallergen (ex: dust mites, mold, pet dander), **AND**
5. Patient is not receiving Xolair in combination with any of the following:
   Anti-interleukin 4 therapy [e.g., Dupixent (dupilumab)]
   Anti-interleukin 5 therapy [e.g., Nucala (mepolizumab), Cinqair (reslizumab), Fasenra (benralizumab)]
   Thymic stromal lymphopoietin (TSLP) inhibitor [e.g., Tezspire (tezepelumab)]

AND

6. Documented Dose and Frequency must be submitted and must be within the FDA approved Dosing and Frequency, **AND**
7. The drug is prescribed by a board-certified or board-eligible allergist or immunologist, pulmonologist or otorhinolaryngologist; **AND**
8. Recent IgE testing (defined as any time prior to treatment but within 6 months) within the below ranges:
   a. Age 6 -11 years old: IgE levels 30 to 1300 IU/mL
   b. Age 12 years and older: IgE levels 30 to 700 IU/mL

Note: Initial authorization will be for no more than 12 months

II. Chronic Idiopathic Urticaria (CIU)

1. A diagnosis of chronic idiopathic urticaria (CIU), **AND**
2. Age ≥ 12 years, **AND**
3. At least a 6-week history of urticaria (presence of hives), **AND**
4. Documented failure, contraindication, or intolerance to a four-week trial of one second-generation non-sedating histamine receptor type 1 (H1) antihistamine (ex: loratadine, cetirizine), **AND**
5. Patient is not receiving Xolair in combination with any of the following:
   Anti-interleukin 4 therapy [e.g., Dupixent (dupilumab)]
   Anti-interleukin 5 therapy [e.g., Nucala (mepolizumab), Cinqair (reslizumab), Fasenra (benralizumab)]
   Thymic stromal lymphopoietin (TSLP) inhibitor [e.g., Tezspire (tezepelumab)]

AND

6 Documented Dose and Frequency must be submitted and must be within the FDA approved Dosing and Frequency, **AND**
7. The drug is prescribed by a board-certified or board-eligible allergist or immunologist, pulmonologist or otorhinolaryngologist or Dermatologist, **AND**
8. Documented failure, contraindication, or intolerance to at least a two-week trial of **ONE** (1) of the following medications:
   a. Leukotriene receptor antagonist (ex: montelukast, zafirlukast), **OR**
   b. Histamine H2-receptor antagonist (ex: famotidine, ranitidine), **OR**
   c. First-generation (sedating) H1 antihistamine (ex: diphenhydramine, hydroxyzine), **OR**
   d. Substitution to a different second-generation non-sedating H1 antihistamine

Note: Initial authorization will be for no more than 12 months

III. Reduction of type I allergic reactions to food

1. A diagnosis of IgE-mediated food allergy, **AND**
2. Age ≥ 1 year, AND
3. Patient is not receiving Xolair in combination with any of the following:
   Anti-interleukin 4 therapy [e.g., Dupixent (dupilumab)]
   Anti-interleukin 5 therapy [e.g., Nucala (mepolizumab), Cinqair (reslizumab), Fasenra (benralizumab)]
   Thymic stromal lymphopoietin (TSLP) inhibitor [e.g., Tezspire (tezepelumab)]

AND

4. The drug is prescribed by a board-certified or board-eligible allergist or immunologist, pulmonologist or otorhinolaryngologist; **AND**
5. Documented Dose and Frequency must be submitted and must be within the FDA approved Dosing and Frequency.
6. Xolair will be used in conjunction with food allergen avoidance**, AND**
7. Patient has been prescribed epinephrine for emergency treatment, **AND**

8. A. Patient has a documented IgE-mediated food allergy to at least **one (1)** of the following:
   a. Cashew
   b. Egg
   c. Hazelnut
   d. Wheat

   AND

   B. IgE-mediated food allergy to the specific food has been confirmed by **both** of the following:
   a) History of type I allergic reactions (e.g., nausea, vomiting, cramping, diarrhea, flushing, pruritus, urticaria, swelling of the lips, face or throat, wheezing, lightheadedness, syncope, anaphylaxis) within a short period of time following a known ingestion of the specific food; **AND**
   b) **One (1)** of following:
      i) Food specific skin prick testing (SPT), **OR**
      ii) IgE antibody in vitro testing, **OR**
      iii) Oral food challenge (OFC)

OR

9. A. Patient has a documented IgE-mediated food allergy to at least **one (1)** of the following:
   1. Milk
   2. Peanut
   3. Tree nuts

AND

B. IgE-mediated food allergy to the specific food has been confirmed by **one (1)** of the following:
   i. Food specific skin prick testing (SPT), **OR**
   ii. IgE antibody in vitro testing, **OR**
   iii. Oral food challenge (OFC)

Note: Initial authorization will be for no more than 12 months

IV. Nasal Polyps

1. A diagnosis of nasal polyps, **AND**
2. Age ≥ 18 years, **AND**
3. Concurrent use of nasal corticosteroids, **AND**
4. The drug is prescribed by a board-certified or board-eligible allergist or immunologist, pulmonologist or otorhinolaryngologist; **AND**

5. Documented Dose and Frequency must be submitted and must be within the FDA approved Dosing and Frequency.

NOTE: Xolair is **NOT** covered except for the conditions listed above. *Coverage requests for indications other than above is considered **NOT MEDICALLY NECESSARY** and therefore not covered. Initial authorization will be for no more than 12 months*

Prior Use Criteria

The plan uses prescription claim records to support criteria for prior use within previous 130 days or the trial and failure of formulary alternatives when available. Additional documentation will be required from the provider when historic prescription claim data is either not available or the medication fill history fails to establish criteria for prior use or trial and failure of formulary alternatives. Documentation will also be required to support any clinical reasons preventing the trial and failure of formulary alternatives. Please see the section on documentation requirements for more information.

Provider Documentation Requirements

Documentation from the provider to support a reason preventing trial of formulary alternative(s) must include the name and strength of alternatives tried and failed (if alternatives were tried, including dates if available) and specifics regarding the treatment failure. Documentation to support clinical basis preventing switch to formulary alternative should also provide specifics around clinical reason.

Individual Consideration (For Atypical Patients)

Our medical policies are written for most people with a given condition. Each policy is based on peer reviewed clinical evidence. We also take into consideration the needs of atypical patient populations and diagnoses.

If the coverage criteria outlined is unlikely to be clinically effective for the prescribed purpose, the health care provider may request an exception to cover the requested medication based on an individual's unique clinical circumstances. This is also referred to as "individual consideration" or an "exception request."

Some reasons why you may need us to make an exception include: therapeutic contraindications; history of adverse effects; expected to be ineffective or likely to cause harm (physical, mental, or adverse reaction).

To facilitate a thorough and prompt review of an exception request, we encourage the provider to include additional supporting clinical documentation with their request. This may include:

- Clinical notes or supporting clinical statements;
- The name and strength of formulary alternatives tried and failed (if alternatives were tried) and specifics regarding the treatment failure, if applicable;
- Clinical literature from reputable peer reviewed journals;
- References from nationally recognized and approved drug compendia such as American Hospital Formulary Service® Drug Information (AHFS-DI), Lexi-Drug, Clinical Pharmacology, Micromedex or Drugdex®; and
- References from consensus documents and/or nationally sanctioned guidelines.

Providers may call, fax or mail relevant clinical information, including clinical references for individual patient consideration, to:

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

We may also use prescription claims records to establish prior use of formulary alternatives or to show if step therapy criteria has been met. We will require the provider to share additional information when prescription claims data is either not available or the medication fill history fails to establish use of preferred formulary medications or that step therapy criteria has been met.

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

HCPCS codes:	Code Description
J0517	Injection, benralizumab, 1 mg
J2182	Injection, mepolizumab, 1 mg (**Nucala** ®)
J2357	Injection, omalizumab, 5 mg (**Xolair** ™)
J2786	Injection, reslizumab, 1 mg (**Cinqair** ®)

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

Policy History

Date	Action
1/2025	Clarified criteria for Xolair 's indication for reduction of type I allergic reactions to food, Urticaria, and Asthma and added Fasenra's new indication.
10/2024	Updated Fasenra age limit.
8/2024	Updated prescriber requirements to the medications in the policy and dose and Frequency requirements.
10/2023	Reformatted Policy and updated IC to align with 118E MGL § 51A.

7/2023	Update to remove specialist requirement for Xolair.
4/2022	Updated to add Tezspire ™ to the policy.
8/2021	Updated to add New indication for Nucala ®.
1/2021	Updated to add new indication for Xolair ®.
10/2020	Updated to add new indication for Nucala ®. Removed deleted codes
4/2020	Updated criteria for Xolair on CIU diagnosis
11/2019	Updated age requirements for Nucala ®.
7/2019	Updated to add CinQair®, Nucala ®, and Fasenra™ to the Med UM program.
1/2019	Clarified coding information.
4/2018	Clarified coding information.
2/2018	Updated to include Fasenra™ and a new indication for Nucala ®.
10/2017	Updated to clarify pediatric IgE levels.
6/2017	Update address for Pharmacy Operations.
1/2017	Updated to include New HCPCS/CPT codes.
10/2016	Updated to include CinQair® and allow all three medications to be billed on both Medical & Pharmacy.
6/2016	Updated to include Nucala® to Medical Only and changed the Policy Name.
7/2014	Updated to include ICD-10 and updated with new Indication CIU.
1/2014	Updated ExpressPAth language.
3/2012	Reviewed – Medical Policy Group - Allergy, Asthma, Immunology and ENT/Otolaryngology. No changes to policy statements.
11/2011-4/2012	Medical policy ICD 10 remediation: Formatting, editing and coding updates. No changes to policy statements.
3/2011	Reviewed - Medical Policy Group - Allergy and ENT/Otolaryngology. No changes to policy statements.
3/2010	Reviewed - Medical Policy Group - Allergy and ENT/Otolaryngology. No changes to policy statements.
10/2009	Updated to reflect UM guidelines.
3/2009	Reviewed - Medical Policy Group - Allergy and ENT/Otolaryngology. No changes to policy statements.
3/2008	Reviewed - Medical Policy Group - Allergy and ENT/Otolaryngology. No changes to policy statements.
3/2007	Reviewed - Medical Policy Group - Allergy and ENT/Otolaryngology. No changes to policy statements.
9/2003	New policy, effective 9/2003, describing covered and non-covered indications.

Forms

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

https://www.bluecrossma.org/medical-policies/sites/g/files/csphws2091/files/acquiadam-assets/023%20E%20Form%20medication%20prior%20auth%20instruction%20prn.pdf

OR

Print and fax, Massachusetts Standard Form for Medication Prior Authorization Requests #434

References

1. Xolair™ subcutaneous injection [package insert]. South San Francisco, CA and East Hanover, NJ: Genentech, Inc. and Novartis Pharmaceuticals Corporation; June 2003.
2. Solèr M, Matz J, Townley R, et al. The anti-IgE antibody omalizumab reduces exacerbations and steroid requirement in allergic asthmatics. *Eur Respir J.* 2001;18:254-261.
3. Buhl R, Solèr M, Matz J, et al. Omalizumab provides long-term control in patients with moderate-to-severe allergic asthma. *Eur Respir J.* 2002;20:73-78.
4. Buhl R, Hanf G, Solèr M, et al. The anti-IgE antibody omalizumab improves asthma-related quality of life in patients with allergic asthma. *Eur Respir J.* 2002;20:1088-1094.
5. Busse W, Corren J, Lanier BQ, et al. Omalizumab, anti-IgE recombinant humanized monoclonal antibody, for the treatment of severe allergic asthma. *J Allergy Clin Immunol.* 2001;108(2):184-190.

6. Finn A, Gross G, van Bavel J, et al. Omalizumab improves asthma-related quality of life in patients with severe allergic asthma. *J Allergy Clin Immunol.* 2003;111(2):278-284.
7. Holgate S, Bousquet J, Wenzel S, Fox H, Liu J, Castellsague J. Efficacy of omalizumab, an anti-immunoglobulin E antibody, in patients with allergic asthma at high risk of serious asthma-related morbidity and mortality. *Curr Med Res Opin.* 2001;17(4):233-240.
8. Nucala ® [package insert]. Philadelphia, PA: GlaxoSmithKline LLC; Nov 2015.
9. Cinqair ® [package insert]. Frazer, PA: Teva Pharmaceutical Industries Ltd; Mar 2016.
10. Faserna ™ [package insert]. Wilmington, DE: AstraZeneca Pharmaceuticals LP; Nov 2017.
11. Bernstein JA, Lang DM, Khan DA, et al. The diagnosis and management of acute and chronic urticaria: 2014 update. *J Allergy Clin Immunol.* 2014 May;133(5):1270-7.