CLINICAL MEDICATION POLICY	
Policy Name:	Interleukin-5 Inhibitors
Policy Number:	MP-007-MC-ALL
Responsible Departments:	Medical Management, Medical Policy, Clinical Pharmacy
Provider Notice Date:	04/1/2017
Original Effective Date:	05/01/2017
Annual Approval Date:	03/15/2018
Revision Date:	N/A
Products:	Kentucky Medicare Assured
Application:	All participating and nonparticipating hospitals and providers
Page Number(s):	1 of 8

Disclaimer

Gateway Health℠ (Gateway) clinical medication policy is intended to serve only as a general reference resource regarding payment and coverage for the services described. This policy does not constitute medical advice and is not intended to govern or otherwise influence medical decisions.

POLICY STATEMENT

Gateway Health℠ may provide coverage under the medical or pharmacy benefits of the Company's Medicare products for medically necessary Interleukin-5 Inhibitors.

This policy is designed to address medical necessity guidelines that are appropriate for the majority of individuals with a particular disease, illness or condition. Each person's unique clinical circumstances warrant individual consideration, based upon review of applicable medical records.

DEFINITIONS

FEV1 – Forced expiratory volume in 1 second.

FVC – Forced vital capacity.

PEF – Peak expiratory flow.

Mild Intermittent Asthma – defined as:

- Symptoms ≤ 2 times a week
- Asymptomatic and normal PEF between exacerbations
- Exacerbations brief (from a few hours to a few days); intensity may vary
- Nighttime symptoms ≤ 2 times a month
- FEV1 or PEF ≥ 80% predicted
- PEF variability < 20%

Mild Persistent Asthma – defined as:

- Symptoms > 2 times a week but < 1 time a day
- Exacerbations may affect activity
- Nighttime symptoms > 2 times a month
- FEV1 or PEF ≥ 80% predicted
- PEF variability 20% to 30%

Moderate Persistent Asthma – defined as:

- Daily symptoms
- Nighttime symptoms > 1 time a week
- Daily use of inhaled short-acting beta2-agonist
- Exacerbations may affect activity
- Exacerbations ≥ 2 times a week; may last days
- FEV1 or PEF > 60% but less than 80% predicted
- PEF variability > 30%

Severe Persistent Asthma – defined as:

- Continual symptoms (i.e., coughing, dyspnea, wheezing)
- Limited physical activity
- Frequent exacerbations
- Frequent nighttime symptoms
- FEV1 or PEF ≤ 60% predicted
- PEF variability > 30%

PROCEDURES

This medical policy addresses two specific medications: Nucala® (mepolizumab) and Cinqair® (reslizumab).

1. Coverage will be provided for Interleukin-5 Inhibitor drugs when the following medical necessity criteria are met:
   A. The patient is at least 12 years of age for Nucala OR the patient is at least 18 years of age for Cinqair; AND
   B. The medication is being prescribed by, or in consultation with, a pulmonologist, allergist, or immunologist; AND
   C. The patient has a confirmed diagnosis of asthma consistent with all of the following:
      1) The medical history and physical exam findings are consistent with a diagnosis of asthma per the most recent Global Initiative for Asthma (GINA) or the National Heart, Lung, and Blood Institute (NHLBI) guidelines for the diagnosis and management of asthma; AND
      2) Spirometry shows obstruction; AND
      3) Evidence of reversibility demonstrated by either an increase in the FEV1 of ≥ 12% from baseline or by an increase of ≥ 10% of predicted FEV1 after inhalation of a short-acting bronchodilator; AND
   D. The patient's asthma is classified as severe and is confirmed by one or more of the following components of severity:
      1) Asthma symptoms such as cough, wheezing, or dyspnea that occur throughout the day;
      2) Nighttime awakenings occurring 7 times a week;
      3) Use of a rescue inhaler such as a long-acting beta2-agonist several times per day;
      4) FEV1 < 60% of predicted;
      5) FEV1/FVC reduced by 5%; AND
   E. The patient has an eosinophilic phenotype consistent with one of the following:
      1) For Nucala:
         a. Blood eosinophil levels are ≥ 150 cells/mm3 at initiation; OR
         b. Blood eosinophil levels have been ≥ 300 cells/mm3 in the past 12 months

      OR
      2) For Cinqair
         a. Blood eosinophil levels are ≥ 400 cells/mm3 within the previous 4 weeks (prior treatment with Cinqair); AND
   F. Other causes of eosinophilia have been ruled out; AND
   G. Symptoms have been uncontrolled, AND the patient has been adherent to controller medications, which includes an inhaled corticosteroid plus another agent, for ≥ 3 months; OR
   H. The patient has experienced ≥ 2 asthma exacerbations in the previous 12 months that required a higher level of care despite adherence to controller medications, which includes an inhaled corticosteroid plus another agent; AND

I. Pharmacy claims data must demonstrate consistent fills of at least medium-dosed inhaled corticosteroids (approximately ≥ 440 mcg fluticasone propionate-equivalent [refer to Attachment C]) for the past 3 months; AND
J. The requested medication will be used in conjunction with traditional controller medications (inhaled corticosteroids, long-acting inhaled beta agonists, mast cell stabilizers, leukotriene modifiers); AND
K. The patient does not have a current parasitic (helminth) infection; AND
L. Any other criteria relating to the specific agent requested, as follows:
    1) Reslizumab (Cinqair)
        a. The dose does not exceed 3 mg/kg intravenously every 4 weeks
    2) Mepolizumab (Nucala)
        a. The dose does not exceed 100 mg subcutaneously every 4 weeks
        b. Consider administration of varicella vaccination if clinically appropriate due to risk of Herpes Zoster infection.

Note: In order to receive continued coverage for these medications, the following information must be documented in the patient's medical record:
1) There is documentation of an up-to-date office visit
2) There is documentation of one or more of the following:
    a. Decrease in asthma exacerbations
    b. Decrease in asthma-related hospitalization
    c. Decrease in asthma-related emergency room visits
    d. Decreased requirement for oral and/or inhaled corticosteroid therapy evidenced by chart documentation or pharmacy claims (if appropriate)
    e. A reduction in reported asthma-related symptoms
    f. Documentation of improvement in FEV1 from pretreatment baseline

2. Contraindications
The safety and efficacy in pediatric individuals younger than 12 years of age have not been established.

3. When Nucala and Cinqair services are not covered
Nucala and Cinqair services are not covered for conditions other than those listed above because the scientific evidence has not been established.

Coverage may be provided for any non-FDA labeled indication if it is determined that the use is a medically accepted indication supported by nationally recognized pharmacy compendia or peer-reviewed medical literature for treatment of the diagnosis(es) for which it is prescribed. These requests will be reviewed on a case-by-case basis to determine medical necessity.

When criteria are not met, the request will be forwarded to a Medical Director for review. The physician reviewer must override criteria when, in their professional judgment, the requested medication is medically necessary.

4. Post-payment Audit Statement
   The medical record must include documentation that reflects the medical necessity criteria and is subject to audit by Gateway Health℠ at any time pursuant to the terms of your provider agreement.

5. Place of Service
   The place of service for administration of Nucala or Cinqair is outpatient.

Coverage Determination
Gateway Health℠ follows the coverage determinations made by CMS as outlined in either the national coverage determinations (NCD) or the state-specific local carrier determination (LCD).

There is no specific NCD for these medications. For Kentucky, CGS, the local carrier, does not have a specific LCD for Interleukin-5 Inhibitors. For additional information, please see:
http://www.cgsmedicare.com/partb/medicalpolicy/index.html

Governing Bodies Approval
On November 4, 2015, the U.S. Food and Drug Administration approved mepolizumab (Nucala) for use with other asthma medicines for the maintenance treatment of asthma in patients aged 12 years and older. Mepolizumab (Nucala) is approved for patients who have a history of severe asthma attacks (exacerbations) despite receiving their current asthma medicines.

Mepolizumab (Nucala) is administered once every four weeks by subcutaneous injection by a health care professional into the upper arm, thigh, or abdomen. Mepolizumab (Nucala) is a humanized interleukin-5 antagonist monoclonal antibody produced by recombinant DNA technology in Chinese hamster ovary cells. Mepolizumab reduces severe asthma attacks by reducing the levels of blood eosinophils, a type of white blood cell that contributes to the development of asthma.

On March 28, 2016, the U.S. Food and Drug Administration approved reslizumab (Cinqair) for use with other asthma medicines for the maintenance treatment of asthma in patients aged 18 years and older. Reslizumab (Cinqair) is approved for patients who have a history of severe asthma attacks (exacerbations) despite receiving their current asthma medicines.

Reslizumab (Cinqair) is administered once every four weeks by intravenous infusion in a clinical setting prepared to manage anaphylaxis. Reslizumab (Cinqair) is a humanized interleukin-5 antagonist monoclonal antibody produced by recombinant DNA technology in murine myeloma non-secreting 0 (NS0) cells. Reslizumab (Cinqair) reduces severe asthma attacks by reducing the levels of blood eosinophils, a type of white blood cell that contributes to the development of asthma.

CODING REQUIREMENTS

Procedure Codes

CPT/HCPCS Codes	Description
J3490	Unlisted drugs [when specified as mepolizumab or reslizumab]
J3590	Unclassified biologics [when specified as mepolizumab or reslizumab]
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular
96401	Chemotherapy administration, subcutaneous or intramuscular
J3490	Unlisted drugs [when specified as mepolizumab or reslizumab]

Diagnosis Codes

ICD-10 Code	Description
J45.50	Severe persistent asthma, uncomplicated [add-on maintenance treatment of patients aged 12 years and older]
J45.51	Severe, persistent asthma with (acute) exacerbation [add-on maintenance treatment of patients aged 12 years and older]
J45.52	Severe persistent asthma with status asthmaticus [add-on maintenance treatment of patients aged 12 years and older]
J82	Pulmonary eosinophilia, not elsewhere classified [add-on maintenance treatment of patients aged 12 years and older] [eosinophilic asthma]

Other References

Estimated Clinical Comparability for Low, Medium, and High Daily Doses of Inhaled Corticosteroids			
Adults and Adolescents (12 years and older)			
Drug	**Daily dose (mcg)**		
	Low	**Medium**	**High**
Beclomethasone dipropionate (HFA)	100-200	> 200-400	> 400
Budesonide (DPI)	200-400	> 400-800	> 800
Ciclesonide (HFA)	80-160	> 160-320	> 320
Fluticasone furoate (DPI)	100	n/a	200
Fluticasone propionate (DPI)	100-250	> 250-500	> 500
Fluticasone propionate (HFA)	100-250	> 250-500	> 500
Mometasone furoate	110-220	> 220-440	> 440

Key

DPI: dry powder inhaler
HFA: hydrofluoroalkane
MDI: metered-dose inhaler

Adopted from Global Strategy for Asthma Management and Prevention (2016 Update).

REMBURSEMENT

Participating facilities will be reimbursed per their Gateway Health℠ contract.

POLICY SOURCE(S)

Mepolizumab (Nucala®) Prescribing Information. Accessed on September 13, 2016 and available at: http://www.accessdata.fda.gov/drugsatfda_docs/label/2015/125526Orig1s000Lbl.pdf.

American Academy of Allergy Asthma and Immunology (AAAAI). Practice Parameters: Allergy Diagnostic Testing. Accessed on August 25, 2016 and available at: http://www.aaaai.org.

FDA approves Reslizumab (Cinqair) to treat severe asthma [news release]. Silver Spring, MD. U.S. Food and Drug Administration, March 23, 2016. Accessed on April 8, 2016 and available at: http://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm491980.htm.

Reslizumab (Cinqair) Prescribing Information. Accessed on March 28, 2016 and available at: http://www.accessdata.fda.gov/drugsatfda_docs/label/2016/761033lbl.pdf.

FDA approves Nucala to treat severe asthma [news release]. Silver Spring, MD. U.S. Food and Drug Administration, November 4, 2015. Accessed on January 7, 2016 and available at: http://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm471031.htm.

American Academy of Allergy Asthma and Immunology (AAAAI). Conditions and treatments. Asthma. Accessed on September 13, 2016 and available at: http://www.aaaai.org/.

American Academy of Allergy Asthma and Immunology (AAAAI). AAAAI allergy & asthma medication guide. Accessed on September 13, 2016 and available at: http://www.aaaai.org/conditions-and-treatments/treatments/drug-guide/inhaled-corticosteroids.aspx.

Policy History:

Date	Activity
N/A	LCD/NCD effective date

	QI/UM Committee approval
	Provider effective date