AETNA BETTER HEALTH® Coverage Policy/Guideline			
Name:	Cinqair	Page:	1 of 3
Effective Date:	8/19/2024	Last Review Date:	7/19/2024
Applies to:	☒Maryland	☒Florida Kids	☒Pennsylvania Kid

Intent:

The intent of this policy/guideline is to provide information to the prescribing practitioner outlining the coverage criteria for Cinqair under the patient's prescription drug benefit.

Description:

Cinqair is indicated for the add-on maintenance treatment of patients with severe asthma aged 18 years and older with an eosinophilic phenotype.

Limitations of Use:
- Not for treatment of other eosinophilic conditions
- Not for the relief of acute bronchospasm or status asthmaticus

All other indications are considered experimental/investigational and not medically necessary.

If the member is a current smoker or vaper, they should be counseled on the harmful effects of smoking and vaping on pulmonary conditions and available smoking and vaping cessation options.

Applicable Drug List:

Cinqair

Policy/Guideline:

Documentation

Submission of the following information is necessary to initiate the prior authorization review:

A. For initial requests:
   1. Chart notes or medical record documentation showing baseline blood eosinophil count, or dependance on systemic corticosteroids, if applicable.
   2. Chart notes, medical record documentation, or claims history supporting previous medications tried including drug, dose, frequency, and duration.

B. For continuation requests:
   1. Chart notes or medical record documentation supporting improvement in asthma control.

Prescriber Specialties

This medication must be prescribed by or in consultation with an allergist/immunologist or pulmonologist.

Criteria for Initial Approval:

A. Authorization of 6 months may be granted for adult members who have previously received a biologic drug indicated for asthma in the past year.

1. The member is unable to take Dupixent for the given diagnosis due to a trial and inadequate treatment response or intolerance, or a contraindication. Documentation is required for approval.
2. Member will NOT use the requested medication concomitantly with any other biologic drug or targeted synthetic drug for the same indication.

B. Authorization of 6 months may be granted for treatment of severe asthma when ALL of the following criteria are met:

1. Member is 18 years of age or older.
2. The member is unable to take Dupixent for the given diagnosis due to a trial and inadequate treatment response or intolerance, or a contraindication. Documentation is required for approval.
3. Member meets EITHER of the following criteria:
   a. A baseline blood eosinophil count of at least 400 cells per microliter.
   b. Member is dependent on systemic corticosteroids.
4. Member has uncontrolled asthma as demonstrated by experiencing at least ONE of the following within the past year:
   a. Two or more asthma exacerbations requiring oral or injectable corticosteroid treatment
   b. One or more asthma exacerbation(s) resulting in hospitalization or emergency medical care visit(s)
   c. Poor symptom control (frequent symptoms or reliever use, activity limited by asthma, night waking due to asthma)
5. Member has inadequate asthma control despite current treatment with BOTH of the following medications at optimized doses:
   a. High-dose inhaled corticosteroid
   b. Additional controller (i.e., long-acting beta$_2$-agonist, long-acting muscarinic antagonist, leukotriene modifier, or sustained-release theophylline)
6. Member will continue to use maintenance asthma treatments (e.g., inhaled corticosteroid, additional controller) in combination with the requested medication.
7. Member will NOT use the requested medication concomitantly with any other biologic drug or targeted synthetic drug for the same indication.

Criteria for Continuation of Therapy:

Authorization of 12 months may be granted for treatment of severe asthma when ALL the following criteria are met:

A. Member is 18 years of age or older
B. Asthma control has improved on the requested medication as demonstrated by at least ONE of the following:
   1. A reduction in the frequency and/or severity of symptoms and exacerbations.

2. A reduction in the daily maintenance oral corticosteroid dose.

C. Member will continue to use maintenance asthma treatments (e.g., inhaled corticosteroid, additional controller) in combination with Cinqair.
D. Member will NOT use the requested medication concomitantly with any other biologic drug or targeted synthetic drug for the same indication.

Approval Duration and Quantity Restrictions:

Initial Approval: 6 months

Renewal Approval: 12 months

Quantity Level Limit:
Cinqair 100 mg/10 mL (10 mg/mL) single use vial: 3 vials per 28 days

References:

1. Cinqair [package insert]. West Chester, PA: Teva Respiratory, LLC; June 2020.
2. Castro M, Zangrilli J, Wechsler ME, et al. Reslizumab for inadequately controlled asthma with elevated blood eosinophil counts: results from two multicentre, parallel, double-blind, randomised, placebo-controlled, phase 3 trials. *Lancet Respir Med*. 2015;3(5):355-366.
3. Global Initiative for Asthma (GINA). Global Strategy for Asthma Management and Prevention. 2023 update. Available at:https://ginasthma.org/wp-content/uploads/2023/07/GINA-Full-Report-23_07_06-WMS.pdf. Accessed March 7, 2024.
4. American Academy of Allergy, Asthma & Immunology (AAAAI) 2020 Virtual Annual Meeting. Available at: https://annualmeeting.aaaai.org/. Accessed March 8, 2024.
5. Cloutier MM, Dixon AE, Krishnan JA, et al. Managing asthma in adolescents and adults: 2020 asthma guideline update from the National Asthma Education and Prevention Program. *JAMA*. 2020;324(22): 2301-2317