Wellmark Advantage Health Plan

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Effective Date: 10/06/2022

Xolair® (omalizumab)

HCPCS: J2357

Policy:

Requests must be supported by submission of chart notes and patient specific documentation.

A. Coverage of the requested drug is provided when all the following are met:
   a. FDA approved age
   b. Diagnosis of uncontrolled moderate to severe allergic asthma
      i. Positive skin test or in-vitro reactivity to a perennial aeroallergen
      ii. Chronic administration of systemic corticosteroids or high dose inhaled corticosteroids (listed in table 1) in combination with
         1. Long acting inhaled β2 agonist modifier for at least 3 months fails to maintain adequate control
            OR
         2. Leukotriene modifier for at least 3 months fails to maintain adequate control
            OR
         3. LAMA (long acting muscarinic antagonists) in adults and children ≥ 12 years old for at least 3 months fails to maintain adequate control
      iii. IgE level >30 but <700 IU/mL for patients 12 years of age and older
         OR
         IgE level >30 but <1,300 IU/mL for patients between the ages of 6 to <12 years
   c. Diagnosis of chronic idiopathic urticaria
      i. Must have occurrence of almost daily hives and itching for at least 6 weeks
      ii. Past trial and failure of all of the following for at least 2 months:
         1. Trial and failure of a second-generation antihistamine at the maximal tolerated dose
            AND
         2. Trial and failure of one of the following at maximal dosing:
            a) Another second-generation antihistamine
            b) H2 antagonist
            c) Leukotriene receptor antagonist
            d) First generation antihistamine given at bedtime
            e) Hydroxyzine
            f) Doxepin
      iii. Other diagnoses have been ruled out.
   d. Diagnosis of nasal polyps

i. Patient is currently receiving and will continue to receive standard of care regimen
ii. Inadequate response to treatment with intranasal corticosteroids
iii. Baseline serum total IgE level of 30 IU/mL to 1,500 IU/mL prior to initiating treatment with Xolair

e. Cannot be used in combination with other biologic agents indicated for any of the conditions listed in the policy and other targeted DMARDs
f. For self-administration of Xolair prefilled syringe: the patient has received the first 3 doses under the guidance of a health care provider
    i. After the first 3 doses under the guidance of a health care provider, the member will self-administer Xolair unless clinically unable to do so
g. Trial and failure, contraindication, OR intolerance to the preferred drugs as listed in Wellmark Advantage Health Plan's utilization management medical drug list and/or Wellmark Advantage Health Plan's prior authorization and step therapy documents.

B. Quantity Limitations, Authorization Period and Renewal Criteria
    a. Authorization Period: One year at a time
    b. Quantity Limit: Align with FDA recommended dosing
    c. Renewal Criteria: Clinical documentation must be provided to confirm that current criteria are met and that the medication is providing clinical benefit.

***Note: Coverage may differ for Medicare Part B members based on any applicable criteria outlined in Local Coverage Determinations (LCD) or National Coverage Determinations (NCD) as determined by Center for Medicare and Medicaid Services (CMS). See the CMS website at http://www.cms.hhs.gov/. Determination of coverage of Part B drugs is based on medically accepted indications which have supported citations included or approved for inclusion determined by CMS approved compendia.

Background Information

- Indications
    - For 6 years of age and above with moderate to severe persistent asthma who have a positive skin test or in vitro reactivity to a perennial aeroallergen and whose symptoms are inadequately controlled with inhaled corticosteroids.
    - Chronic idiopathic urticaria in adults and adolescents (12 years of age and above) who remain symptomatic despite H1 antihistamine treatment.
    - For add-on maintenance treatment of nasal polyps in adult patients 18 years of age and older with inadequate response to nasal corticosteroids.
- Xolair is a recombinant Chinese hamster ovary cell-derived IgG1 kappa humanized monoclonal antibody that lowers the incidence of asthma exacerbations in adults and adolescents with moderate to severe persistent asthma characteristically provoked by specific aeroallergens. It has been shown to be beneficial as adjunctive therapy in patients whose symptoms are inadequately controlled despite the regular use of maximum dose inhaled corticosteroids. Xolair should be prescribed as prophylactic therapy for allergy-induced asthma and never used as monotherapy.
- Moderate persistent asthma symptoms include:
    - Symptoms more than once/week but less than once/day
    - Exacerbations may affect activity and sleep

- Nocturnal symptoms more than once/week
- Daily use of inhaled short-acting beta2 agonist
- FEV_1 (forced expiratory volume) 60% to 80% predicted or PEF (peak expiratory flow) 60% to 80% of personal best
- PEF or FEV_1 variability

- Severe persistent asthma symptoms include:
  - Symptoms daily
  - Frequent exacerbations

- Severe asthma requires treatment with high dose inhaled corticosteroids (ICS) plus a second controller (and/or systemic corticosteroids) to prevent it from becoming uncontrolled or which remains uncontrolled despite therapy. Add-on treatment for severe asthma include LAMA, leukotriene receptor antagonist (LTRA), low dose azithromycin (adults) and biologic agents for severe allergic or severe type 2 asthma. Type 2 inflammation is found in a majority of people with severe asthma and is characterized by production of cytokines such as interleukin and can also include immunoglobulin E (IgE)-mediated events involving mast cells and basophils (in particular, mast cells, eosinophils, T lymphocytes, macrophages, neutrophils, and epithelial cells). Anti-IgE monoclonal antibodies reduce the levels of circulating IgE and inhibit the binding of IgE to mast cells to prevent activation of the allergic cascade and decrease inflammation.

- The Global Institute for Asthma (GINA) 2021 guidelines stepwise approach recommend those in STEP 5 to add-therapy with LAMAs such as tiotropium, anti-IgE therapy (omalizumab), anti-IL5 therapy, or anti-IL4 therapy after phenotypic assessment of asthma subtypes.

- The IgE levels in the coverage criteria are based on the efficacy data from the clinical trials of these medications and where they were found to be most effective.

- Review response to biologic therapy after 3-4 months of treatment. If the patient had a good response, the need for each medication should re-evaluated, but do not completely stop inhaled therapy. Consider gradually decreasing or stopping oral steroids first.

- On April 9, 2021, the FDA approved Xolair pre-filled syringe for self administration by certain patients or their caregiver for all indications: asthma in patients 6 years and older, chronic idiopathic urticaria in patients 12 years and older, and nasal polyps in patients 18 years and older. Xolair prefilled syringes were previously for clinician administration only. Xolair's lyophilized powder in a single-dose vial remains clinician administered only. Patients should receive 3 doses of Xolair under the guidance of a health care provider due to risk of anaphylaxis before transitioning to self administration.

- Clinical reasons a patient may be unable to self-administer Xolair include risk factors for anaphylaxis to Xolair among other reasons. Patient-specific factors include:
  - Prior history of anaphylaxis including to Xolair, or other agents such as foods, drugs, or biologics
  - Hypersensitivity reactions during the first 3 doses under the guidance of a healthcare provider

- Patients or caregivers who are unable to recognize symptoms of anaphylaxis
- Patients or caregivers who are unable to treat anaphylaxis appropriately
- Patients or caregivers who are unable to perform subcutaneous injections with proper technique

- In the United States approximately 1.5 million people suffer from chronic idiopathic urticaria (CIU). CIU is characterized by red, swollen, itchy and sometimes painful hives on the skin that spontaneously present and re-occur for more than 6 weeks. Up to 40% of these patients may also experience angioedema. Xolair is the only other drug besides H1-antihistamines that is FDA approved for treatment of CIU.

- Chronic rhinosinusitis with nasal polyps (CRSwNP, also referred to as nasal polyposis or nasal polyps) is a chronic inflammatory disease of the nasal passage lining or sinuses that leads to bilateral, benign soft tissue growth referred to as nasal polyps. It affects 5-12% of the general population worldwide, often occurring with other immunologic conditions such as allergies and/or asthma. The polyps are characterized by elevated eosinophil levels and are most commonly seen in the third and fourth decade of life.

- The cornerstone of treatment for nasal polyps is intranasal corticosteroids as well as nasal saline sprays or irrigation. Systemic corticosteroids may also be used short term (10-15 days) to reduce severe polyp inflammation and symptoms like impaired sense of smell or severe nasal blockage.

- For patients with refractory disease that has not responded to intranasal and oral corticosteroids, biologic therapy and/or functional endoscopic sinus surgery (FESS) may be considered. Surgery must be followed with maintenance therapy with intranasal corticosteroids and other appropriate therapies to prevent recurrence of polyps. No comparative studies or guidelines are available that recommend one treatment option over another for refractory cases.

- Maintenance therapies are initiated once symptoms have been controlled to minimize inflammation and prevent the regrowth of nasal polyps after surgery. The mainstay of maintenance treatment is intranasal glucocorticoids. Leukotriene inhibitors may also be of benefit as adjunctive therapy, particularly if allergic rhinitis or aspirin-exacerbated respiratory disease are suspected contributing factors.

- In June 2019, the IL-4 inhibitor Dupixent® (dupilumab) was the first biologic approved for CRSwNP as add-on maintenance therapy for adults with inadequately controlled CRSwNP. The anti-IgE antibody Xolair became the second biologic for this indication after it was approved in December 2020 for add-on maintenance treatment of nasal polyps in adults 18 years of age and older with an inadequate response to nasal corticosteroids

- Xolair approval for nasal polyps was based on the Phase III POLYP 1 (n=138) and POLYP 2 (n=127) randomized, double-blind, placebo-controlled trials that evaluated the safety and efficacy of Xolair versus placebo in adults with CRSwNP who had an inadequate response to intranasal corticosteroid therapy. Patients were required to have been treated with intranasal corticosteroids for at least 4 weeks prior to the screening visit and received background intranasal mometasone therapy daily during the 5-week run-in period prior to randomization and throughout the treatment period. After 24 weeks of treatment, Xolair-treated patients experienced significantly greater improvements from baseline over placebo for the Nasal Polyp Score (NPS) and Nasal Congestion Score (NCS) with a safety profile consistent with the established safety profile for Xolair. No head-to-head studies have been completed comparing biologic treatments for nasal polyps, nor is there literature available regarding combination use of biologics for the treatment of nasal polyps.

- Xolair for nasal polyps must be administered subcutaneously every 2 or 4 weeks with dosing based on total serum IgE level measured prior to the start of treatment and by body weight. Refer to Appendix D for a complete dosing chart for nasal polyps.

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Policy History		
#	Date	Change Description
1.1	Effective Date: 10/06/2022	Updated criteria to require those who are clinically able to do so, to self-administer Xolair prefilled syringe after the three doses under the supervision of a healthcare provider
1.0	Effective Date: 01/01/2022	New Policy

** The prescribing information for a drug is subject to change. To ensure you are reading the most current information it is advised that you reference the most updated prescribing information by visiting the drug or manufacturer website or http://dailymed.nlm.nih.gov/dailymed/index.cfm.*

Table 1: Comparative cumulative daily dosing of inhaled corticosteroids (mcg/day)

Inhaled Corticosteroid	Ages 12 and up			Ages 6-11		
	Low Dose	Medium Dose	High Dose	Low Dose	Medium Dose	High Dose
Beclometasone dipropionate HFA	100 – 200	>200 – 400	>400	50 – 100	>100 – 200	>200
Budesonide DPI	200 – 400	>400 – 800	>800	100 – 200	>200 – 400	>400
Budesonide nebules	NA	NA	NA	250 – 500	>500 – 1,000	>1,000
Ciclesonide HFA	80 – 160	>160 – 320	>320	80	>80 – 160	>160
Fluticasone furoate DPI	100	NA	200	NA	NA	NA
Fluticasone propionate DPI	100 – 250	>250 – 500	>500	100 – 200	>200 – 400	>400
Fluticasone propionate HFA	100 – 250	>250 – 500	>500	100 – 200	>200 – 500	>500
Mometasone furoate	110 – 220	>220 – 440	>440	110	≥220 - <440	≥440
Triamcinolone acetonide	400 – 1,000	>1,000 – 2,000	>2,000	400 – 800	>800 – 1,200	>1,200