Benefit determinations are based on the applicable contract language in effect at the time the services were rendered. Exclusions, limitations or exceptions may apply. Benefits may vary based on contract, and individual member benefits must be verified. Wellmark determines medical necessity only if the benefit exists and no contract exclusions are applicable. This medical policy may not apply to FEP. Benefits are determined by the Federal Employee Program.

**DESCRIPTION**

The intent of the Cinqair (reslizumab) drug policy is to ensure appropriate selection of patients for therapy based on product labeling, clinical guidelines, and clinical studies as well as requiring the use of the health plan's preferred product Fasenra prior to the use of non-preferred products. Coverage for Cinqair is provided based on clinical circumstances that would exclude the use of the preferred product Fasenra. The coverage review process will ascertain situations where a clinical exception can be made.

**FDA-Approved Indication**

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:**
- Cinqair is not indicated for treatment of other eosinophilic conditions
- Cinqair is not indicated for the relief of acute bronchospasm or status asthmaticus

**POLICY**

**Criteria for Initial Approval**

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

1. Member meets any of the following exception criteria for non-preferred product
   a) Member has had a documented inadequate response to the preferred product Fasenra
   b) Member has experienced a documented intolerable adverse event with the preferred product Fasenra
2. Member is 18 years of age or older
3. Member has baseline blood eosinophil count of at least 400 cells per microliter
4. Member has inadequate asthma control (e.g., hospitalization or emergency medical care visit within the past year) despite current treatment with both of the following medications at optimized doses:
   a) Inhaled corticosteroid
   b) Additional controller (long acting beta2-agonist, leukotriene modifier, or sustained-release theophylline)

**Continuation of Therapy**
Authorization of 12 months may be granted for treatment of eosinophilic asthma when ALL of the following criteria are met:

- Member meets any of the following exception criteria for non-preferred product
  a) Member has had a documented inadequate response to the preferred product Fasenra
  b) Member has experienced a documented intolerable adverse event with the preferred product Fasenra
- Member is 18 years of age or older
- Asthma control has improved on Cinquair treatment, demonstrated by a reduction in the frequency and/or severity of symptoms and exacerbations

Cinqair is considered not medically necessary for members who do not meet the criteria set forth above.

**PROCEDURES AND BILLING CODES**

To report provider services, use appropriate CPT* codes, Alpha Numeric (HCPCS level 2) codes, Revenue codes, and/or ICD diagnostic codes.

- J2786 Injection, reslizumab, 1mg

**REFERENCES**


**POLICY HISTORY**

Policy #: 05.01.117
Original Effective Date: July 2016
Reviewed: April 2018
Revised: January 2019
Current Effective Date: February 4, 2019