Clinical Policy: Omalizumab (Xolair)

Reference Number: CP.PHAR.01
Effective Date: 10/08
Last Review Date: 07/17

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description
The intent of the criteria is to ensure that patients follow selection elements established by Centene® clinical policy for omalizumab (Xolair®).

Policy/Criteria
It is the policy of health plans affiliated with Centene Corporation® that omalizumab is **medically necessary** when one of the following criteria are met:

I. Initial Approval Criteria

A. Moderate to Severe Persistent Asthma (must meet all):

1. Prescribed by or in consultation with an allergist or pulmonologist;
2. Age ≥ 6 years;
3. Diagnosis of moderate to severe persistent asthma;
4. Member has experienced ≥ 2 exacerbations requiring oral/systemic corticosteroid treatment, urgent care visit or hospital admission within the last 12 months despite adherent use of controller therapy (i.e., high dose inhaled corticosteroid [ICS] plus either a long acting beta-2 agonist [LABA] or leukotriene modifier [LTRA] if LABA contraindicated/intolerance);
5. Positive immunoassay or skin test to perennial aeroallergen identified to be an asthma trigger;
6. Immunoglobulin E (IgE) level ≥ 30 IU/mL;
7. If current smoking history, engaged in smoking cessation effort;
8. Xolair is prescribed concomitantly with an ICS plus either an LABA or LTRA;
9. Prescribed dose does not exceed 375 mg administered every 2 weeks (a and b):
   a. Dose is based on pre-treatment IgE level, weight, and age per Appendix B or C;
   b. Per manufacturer, dose adjustment following Appendix B or C is recommended for significant changes in body weight during treatment.

Approval duration: 6 months

B. Chronic Idiopathic Urticaria (must meet all):

1. Age ≥ 12 years;
2. Prescribed by or in consultation with a dermatologist or allergist;
3. Diagnosis of chronic idiopathic urticaria (CIU);
4. Failure of both of the following unless contraindication/intolerance (a and b):
   a. Two antihistamines (including one second generation antihistamine – e.g., cetirizine, levocetirizine, fexofenadine, loratadine, desloratadine, ranitidine, famotidine, cimetidine) at maximum indicated doses for ≥ 4 weeks;
   b. An LTRA with an antihistamine at maximum indicated doses for ≥ 4 weeks;

5. Prescribed dose does not exceed 300 mg every 4 weeks.

Approval duration: 6 months

C. Other diagnoses/indications: Refer to CP.PHAR.57 - Global Biopharm Policy.

II. Continued Approval

A. Moderate to Severe Persistent Asthma (must meet all):

1. Currently receiving medication via Centene benefit or member has previously met all initial approval criteria;
2. Demonstrated adherence to asthma controller therapy that includes an ICS plus either a LABA or LTRA;
3. Member is responding positively to therapy as evidenced by reduction in exacerbations or corticosteroid dose, or improvement in FEV_1 since baseline;
4. Prescribed dose does not exceed 375 mg administered every 2 weeks (a and b):
   a. Dose is based upon pre-treatment IgE level, weight, and age per Appendix B or C;
   b. Per manufacturer, dose adjustment following Appendix B or C is recommended for significant changes in body weight during treatment.

Approval duration: 12 months

B. Chronic Idiopathic Urticaria (must meet all):

1. Currently receiving medication via Centene benefit or member has previously met all initial approval criteria;
2. Documentation supports positive response to therapy;
3. Prescribed dose does not exceed 300 mg every 4 weeks.

Approval duration: 12 months

C. Other diagnoses/indications (1 or 2)**:**

1. Currently receiving medication via Centene benefit and documentation supports positive response to therapy.
   Approval duration: Duration of request or 6 months (whichever is less); or
2. Refer to CP.PHAR.57 - Global Biopharm Policy.

Background

Description/Mechanism of Action:

Xolair is a recombinant DNA-derived humanized IgG1κ monoclonal antibody that selectively binds to human IgE.

Asthma: Omalizumab inhibits the binding of IgE to the high-affinity IgE receptor (FcεRI) on the surface of mast cells and basophils. Reduction in surface-bound IgE on FcεRI-bearing cells limits the degree of release of mediators of the allergic response. Treatment with Xolair also reduces the number of FcεRI receptors on basophils in atopic patients.

Chronic idiopathic urticaria: Omalizumab binds to IgE and lowers free IgE levels. Subsequently, IgE receptors (FcεRI) on cells down-regulate. The mechanism by which these effects of omalizumab result in an improvement of CIU symptoms is unknown.

Formulations:
Xolair: Reconstituted preservative free solution for subcutaneous administration: 150 mg (single-use vial).

FDA Approved Indications:
Xolair is a monoclonal antibody/subcutaneous injection indicated for:

- Moderate to severe persistent asthma
  - Patients ≥ 6 years of age 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.

  Limitations of use:
  - Xolair is not indicated for the relief of acute bronchospasm or status asthmaticus;
  - Xolair is not indicated for treatment of other allergic conditions;
- Chronic idiopathic urticaria
  - The treatment of adults and adolescents (≥ 12 years of age) with chronic idiopathic urticaria who remain symptomatic despite H1 antihistamine treatment.

  Limitations of use:
  - Xolair is not indicated for treatment of other forms of urticaria.

Appendices

Appendix A: Abbreviation Key

CIU: chronic idiopathic urticaria
FcεRI: high-affinity IgE receptor
FEV: forced expiratory volume
ICS: inhaled corticosteroids
IgE: immunoglobulin E
IgG: immunoglobulin G
LABA: long acting beta-2 agonist
LTRA: leukotriene modifier

Appendix B: Age ≥ 12 years: Dosing based on pre-treatment IgE and body weight†

Pre-treatment serum IgE IU/mL	Dosing Frequency	Body Weight			
		30-60 kg	>60-70 kg	>70-90 kg	>90-15 kg
≥ 30-100	Every 4 weeks	150 mg	150 mg	150 mg	300 mg
> 100-200		300 mg	300 mg	300 mg	225 mg
> 200-300		300 mg	225 mg	225 mg	300 mg
> 300-400	Every 2 weeks	225 mg	225 mg	300 mg	
> 400-500		300 mg	300 mg	375 mg	
> 500-600		300 mg	375 mg	DO NOT DOSE PER MANUFACTURER	
> 600-700		375 mg			

†The manufacturer recommends dose adjustments for significant body weight changes during treatment.

Appendix C: Age 6 to < 12 years: Dosing based on pre-treatment IgE and body weight†

Pre-treatment serum IgE IU/mL	Dosing Frequency	Body Weight									
		20-25 kg	>25-30 kg	>30-40 kg	>40-50 kg	>40-50 kg	>40-50 kg	>40-50 kg	>40-50 kg	>40-50 kg	>40-50 kg
≥ 30-100	Every 4 weeks	75	75	75	150	150	150	150	150	300	300
>100-200		150	150	150	300	300	300	300	300	225	300
>200-300		150	150	225	300	300	225	225	225	300	375
>300-400		225	225	300	225	225	225	300	300		
>400-500		225	300	225	225	300	300	375	375		
>500-600		300	300	225	300	300	375				
>600-700		300	225	225	300	375					
>700-800	Every 2 weeks	225	225	300	375	DO NOT DOSE PER MANUFACTURER					
>800-900		225	300	375							
>900-1000		225	300	375							
>1100-1200		300	300								
>1200-1300		300	375								

†The manufacturer recommends dose adjustments for significant body weight changes during treatment.

Coding Implications

Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

HCPCS Codes	Description
J2357	Injection, omalizumab, 5 mg

Reviews, Revisions, and Approvals	Date	Approval Date
Added questions regarding dosing to algorithms and Appendix C dosing tables	12/13	12/13
Removed peak flow meter reading improvement from reauthorization algorithm	02/14	03/14
Added indication for urticaria	06/14	06/14
Reworded FDA-approved indication to mirror package insert. Added safety section to discuss black box warning. Appendix B: Modified appendix to require use of high-dose corticosteroids along with leukotriene modifiers, rather than leukotriene modifiers by themselves. Figure 1: Modified wording to read "Does patient practice adequate ICS dose titration or use of oral steroid therapy for asthma exacerbations?" Figure 3: Modified algorithm to require failure or intolerance to at least two (rather than one) H1 antihistamines at maximum tolerated doses.	04/15	05/15

Reviews, Revisions, and Approvals	Date	Approval Date
Policy converted to new format. Age included per PI; all documentation requests removed; modified requirement for 3 months of adherent use to requirement for at least 2 exacerbations in the last 12 months despite adherent use of controller medication; changed "RAST" to "immunoassay." Changed requirement for nonsmoker and nonsmoking home to engaged in smoking cessation efforts if smoker. Added requirement for concomitant use of maintenance therapy in asthma, failure or contraindication to step therapy for CIU, maximum allowed dose to asthma and CIU criteria; "positive response" to CIU continuation criteria; definition of positive response to asthma continuation criteria; safety information to background regarding anaphylaxis and provider administration of Xolair. Removed criteria regarding response to therapy and rescuer inhaler use from asthma renewal criteria; questions about adverse reaction to Xolair for continuation of therapy requirement for both asthma and CIU.	3/16	5/16
Minimum age changed to 6 for asthma, per PI. Added pediatric dosing to Appendix B.	9/16	9/16
Asthma step therapy edited to require LABAs before LTRAs unless contraindicated or intolerant. Added positive response to therapy under continued approval. CIU: Examples of second-generation antihistamines added.	02/17	02/17
Initial criteria: IgE level between 30-700 IU/mL is edited to read "between 30-1300 IU/mL" per PI.	03/17	
Requirement for FEV1 < 80% is removed from the asthma criteria. Approval durations increased from 3/6 to 6/12 months.	07/17	07/17

References

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3. Wenzel S. Evaluation of severe asthma in adolescents and adults. In: UpToDate, Waltham, MA: Wolters Kluwer Health; 2017. Available at uptodate.com. Accessed July 6, 2017.
4. Wenzel S. Treatment of severe asthma in adolescents and adults. In: UpToDate, Waltham, MA: Wolters Kluwer Health; 2017. Available at uptodate.com. Accessed July 6, 2017.
5. Bernstein JA, Lang DM, Khan DA, et al. The diagnosis and management of acute and chronic urticaria: 2014 update. *J Allergy Clin Immunol*. 2014; 133(5); 1270-1277.

6. Khan DA. Chronic urticarial: Standard management and patient education. In: UpToDate, Waltham, MA: Wolters Kluwer Health; 2017. Available at uptodate.com. Accessed July 6, 2017.

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.