

New Hampshire Medicaid Fee-for-Service Program Asthma/Allergy Immunomodulator Criteria

Approval Date: August 7, 2020

Indications

Omalizumab is an anti-IgE antibody indicated for moderate to severe persistent asthma in patients ≥ 12 years old inadequately controlled with inhaled corticosteroids or for chronic idiopathic urticaria.

Mepolizumab is an interleukin-5 antagonist monoclonal antibody (IgG1 kappa) indicated for add-on maintenance treatment of patients with severe asthma who are ≥ 12 years old with an eosinophilic phenotype.

Reslizumab is an interleukin-5 antagonist monoclonal antibody (IgG1 kappa) indicated for add-on maintenance treatment of patients with severe asthma ≥ 18 years old with an eosinophilic phenotype.

Benralizumab is interleukin-5 receptor alpha-directed cytolytic monoclonal antibody (IgG1 kappa) indicated for add-on maintenance treatment of patients with severe asthma who are ≥ 12 years old with an eosinophilic phenotype.

Medications

Brand Names	Generic Names	Dosage
Cinqair [®]	reslizumab	100 mg/10 mL vial
Fasenra [®]	benralizumab	30 mg/mL single-dose prefilled syringe (HCP); 30 mg/mL prefilled single-dose autoinjector (self-administered)
Nucala [®]	mepolizumab	100 mg powder for reconstitution, 100 mg/1 mL single-dose, prefilled autoinjector and single-dose prefilled syringe
Xolair [®]	omalizumab	150 mg/5 mL vial, 75 mg/0.5 mL, and 150 mg/1 mL single-dose prefilled syringe

For requests for dupilumab (Dupixent[®]) use the Dupixent[®] criteria

Criteria for Approval

1. Prescriber is an allergist, immunologist, or pulmonologist (or one of these specialists has been consulted); **AND**
2. Patient is ≥ 6 years old (Nucala[®]), ≥ 12 years old (Xolair[®] or Fasenna[®]) or ≥ 18 years old (Cinqair[®]); **AND**
3. Diagnosis of chronic idiopathic urticaria (for Xolair[®] only); **OR**
4. Diagnosis of moderate (for Xolair[®] only) or severe, persistent asthma; **AND**
5. Inadequately controlled asthma despite medium-to-high doses of corticosteroid (inhaled or oral) in combination with:
 - a. Long-acting beta agonist; **OR**
 - b. Leukotriene receptor agonist; **OR**
 - c. Theophylline; **AND**
6. History of positive skin test or *in vitro* test to perennial aeroallergen or eosinophilic phenotype; **AND**
7. Non-smoker status; **AND**
8. Pre-treatment serum immunoglobulin E (IgE) (IU/mL) level between 30 and 700 IU/mL (Xolair[®] only).

Length of Authorization

Initial six months, extended approval for 12 months if additional criteria are met.

Criteria for 12-Month Renewal

1. Approved for initial six-month trial; **AND**
2. Clinical improvement was seen.

Criteria for Denial

1. Above criteria are not met; **OR**
2. If being used for peanut allergy only; **OR**
3. Patient is an active smoker; **OR**
4. Failure to be compliant with current regimen as evidenced by review of claims history; **OR**
5. For asthma diagnosis only, no claims history of inhaled corticosteroid, long-acting beta agonist, leukotriene receptor, antagonists or theophylline in the last 120 days for new prescriptions only.

References

Available upon request.

Revision History

Reviewed by	Reason for Review	Date Approved
Pharmacy & Therapeutic Committee	New	09/05/2006
Commissioner	Approval	09/29/2006
Pharmacy & Therapeutic Committee	Update	04/19/2009
Commissioner	Approval	05/12/2009
DUR Board	Update	10/19/2011
Commissioner	Approval	04/12/2012
DUR Board	Update	05/31/2016
Commissioner	Approval	06/18/2016
DUR Board	Update	09/27/2018
Commissioner Designee	Approval	11/27/2018
DUR Board	Update	03/12/2019
Commissioner Designee	Approval	04/05/2019
DUR Board	Update	10/28/2019
Commissioner Designee	Approval	12/03/2019
DUR Board	Update	06/30/2020
Commissioner Designee	Approval	08/07/2020