Omalizumab (Xolair)

Meets Primary Coverage Criteria Or Is Covered For Contracts Without Primary Coverage Criteria

Omalizumab meets member benefit certificate primary coverage criteria that there be scientific evidence of effectiveness in improving health outcomes when **ALL** the following criteria are met:

ASTHMA

INITIAL APPROVAL STANDARD REVIEW for up to 6 months:

1. Individual is 6 years of age or older (Xolair, 2021); **AND**
2. Individual has a diagnosis of moderate to severe persistent asthma (Xolair, 2021)
3. *Evidence of asthma as demonstrated by both of the following (GINA, 2022):

    a. A pretreatment forced expiratory volume in 1 second (FEV1) < 80% predicted for adults or ≤ 90% for children (< 18 years of age); **AND**
    b. Positive bronchodilator responsiveness test evidenced by an increase in FEV1 of > 12% and > 200 mL for adults and > 12% for children (< 18 years of age); **AND**

4. Documentation of inadequate control of symptoms with use of one of the following combination therapies (ERS/ATS, 2014) unless the individual is intolerant of, or has a medical contraindication to these agents:

    a. 3 months of high-dose inhaled corticosteroid (ICS) (equivalent to those defined in the policy guidelines) given in combination with a minimum of 3 months of controller medication (either a long-acting beta2-agonist [LABA], **OR** leukotriene receptor antagonist [LTRA], or theophylline); **OR**

    b. 6 months of ICS with daily oral glucocorticoids (only applicable to a diagnosis of severe asthma); **AND**

5. Individual has one of the following (ERS/ATS, 2014):
    a. A history of 2 or more exacerbations in the previous year, requiring bursts of systemic steroids (>3 days each); **OR**
    b. At least one exacerbation requiring hospitalization, ICU stay or mechanical ventilation in the previous year; **AND**

6. Sensitivity to a perennial aeroallergen by positive skin test or in-vitro IgE test (e.g., ImmunoCap test) must be demonstrated (Xolair, 2021); **AND**
7. For children 6 to <12 years of age, pre-treatment serum IgE must be between 30 and 1300 IU/ml and body weight no more than 150kg (Xolair, 2021); **AND**

8. For adults and adolescents 12 years and older, pre-treatment serum IgE must be between 30 and 700 IU/ml and body weight no more than 150kg (Xolair, 2021); **AND**
9. Individual will continue to use maintenance asthma treatments (e.g., ICS, LABA, LTRA or theophylline) in combination with omalizumab (GINA, 2022); **AND**
10. Individual is not being treated concurrently with another biologic agent for the same or similar condition (such as benralizumab, dupilumab, mepolizumab, reslizumab or tezepelumab); **AND**
11. Must be dosed in accordance with the FDA label; **AND**
12. Must be prescribed by or in consultation with an Allergist/Immunologist or Pulmonologist.

****FeNO testing is non-covered and is not considered adequate for establishing the diagnosis of asthma. Please see AR policy 2005020.**

CONTINUED APPROVAL for up to 1 year:

1. Treatment with omalizumab has resulted in clinical improvement as documented by one or more of the following:

    a. Decreased utilization of rescue medications; **OR**
    b. Decreased frequency of exacerbations (defined as worsening of asthma that requires an increase in ICS dose or treatment with systemic corticosteroids), hospitalizations, and/or ER/urgent visits; **OR**
    c. Increase in predicted FEV1 from pretreatment baseline; **AND**

2. Must be dosed in accordance with the FDA label.

CHRONIC SPONTANEOUS URTICARIA

INITIAL APPROVAL STANDARD REVIEW for up to 6 months:

1. Individual is 12 years of age or older (Xolair, 2021); **AND**
2. Other etiologies of urticaria have been excluded and there is no diagnosis of a more specific etiology (e.g., allergic, contact, vibratory, thermal or cholinergic urticaria) (Xolair, 2021); **AND**
3. Individual has the presence of recurrent urticaria, angioedema or both for a period of at least 6 weeks (Saini, 2021); **AND**
4. There must be a clear documentation of physical findings characteristic of CSU (see policy guidelines (Zuberbier, 2018); **AND**
5. Individual is not being treated concurrently with another biologic agent for the same or similar condition (such as benralizumab, dupilumab, mepolizumab, reslizumab or tezepelumab); **AND**
6. Individual has had an inadequate response to at least four weeks of treatment with a second-generation antihistamine (e.g., cetirizine, desloratadine, fexofenadine, levocetirizine, loratadine) used in combination with an H2-antihistamine (e.g., cimetidine, famotidine) and a leukotriene modifier (e.g., montelukast, zafirlukast) (Bernstein, 2014); **AND**
7. Must be dosed in accordance with the FDA label.

CONTINUED APPROVAL for up to 12 months:

For **ALL** individuals:

1. Must be dosed in accordance with the FDA label; **AND**
2. Individual is not being treated concurrently with another biologic agent for the same or similar condition (such as benralizumab, dupilumab, mepolizumab, reslizumab or tezepelumab).

For individuals who have a duration of therapy < 2 years, documentation of clinical response compared to baseline (reduction in exacerbations, itch severity, hives) must be submitted.

For individuals who have a duration of therapy ≥ 2 years **with continued outbreaks**, documentation of clinical response compared to baseline (reduction in exacerbations, itch severity, hives) must be submitted.

For individuals who duration of therapy is ≥ 2 years **without continued outbreaks AND** whom have documentation of a failed taper or cessation of therapy (of omalizumab) in the past 2 years, documentation must be provided for both of the following:

1. Return or worsening of symptoms (increase in exacerbations, itch severity, hives) during attempted taper of cessation of therapy; **AND**
2. Clinical response to current regimen (reduction in exacerbations, itch severity, hives).

For individuals who have a duration of therapy ≥ 2 years **without continued outbreaks AND** who **LACK** documentation of a failed taper or cessation of therapy: a taper, and if successful, a cessation of therapy will be required. Plan will allow a 12-month approval for provider to taper individual's current regimen. Any request for continuation after attempted taper, must demonstrate the individual's continued need for therapy based on the return or worsening of symptoms during the trial of an appropriate taper (see policy guidelines) or cessation of therapy (Turk, 2018).

CHRONIC RHINOSINUSITIS WITH NASAL POLYPOSIS (CRSwNP)

INITIAL APPROVAL STANDARD REVIEW for up to 6 months:

1. Individual is 18 years of age or older; **AND**
2. Individual is diagnosed with CRSwNP; **AND**
3. Omalizumab is prescribed by a physician with expertise in the treatment of CRSwNP, e.g., an otolaryngologist [ear, nose, and throat (ENT) specialist] OR an allergist/immunologist; **AND**
4. Individual has moderate to severe symptoms of nasal obstructions; **AND**
5. Individual has one of the following:
    a. Rhinorrhea; **OR**
    b. Decreased sense of smell for at least 12 weeks; **AND**
6. Individual has bilateral sinonasal polyposis reaching the lower border of the middle turbinate or beyond, which has been confirmed by nasal endoscopy, anterior rhinoscopy, or sinus CT scan (AAO-HNSF, 2015); **AND**

7. Individual has had at least one prior sinonasal surgery for CRSwNP or is not a candidate for sinonasal surgery to remove polyps – reason(s) for non-candidacy must be provided (AAO-HNS, 2015); **AND**
8. Individual has tried and failed systemic corticosteroids, unless contraindicated, in the past 2 years (AAAAI/ACAAI 2014); **AND**
9. Individual has tried and failed (e.g., lack of significant reduction in size or resolution of nasal polyps), within the last 6 months, at least 8 weeks of continuous treatment with an intranasal corticosteroid post-sinonasal surgery (individuals who are ineligible for sinonasal surgery are still required to have tried intranasal corticosteroids) (AAO-HNS, 2015); **AND**
10. Individual will be using a daily intranasal corticosteroid during treatment with omalizumab, unless contraindicated or not tolerated; **AND**
11. Individual is not being treated concurrently with a biologic agent for the same or similar conditions (such as benralizumab, dupilumab, or mepolizumab); **AND**
12. Must be dosed in accordance with the FDA label.

CONTINUED APPROVAL for up to 1 year:

Requirement of documentation in the medical records that the member has achieved and maintains a clinically meaningful benefit as defined below:

1. Individual has had improvement in clinical signs and symptoms of the disease (including but not limited to improvement in nasal polyp score or nasal congestion score); **AND**
2. Individual meets all of the following initial approval criteria:
    a.Omalizumab is prescribed by a physician with expertise in the treatment of CRSwNP, e.g., an otolaryngologist [ear, nose, and throat (ENT) specialist] **OR** an allergist/immunologist; **AND**
    b. The individual will be using a daily intranasal corticosteroid during treatment with omalizumab, unless contraindicated or not tolerated; **AND**
    c. Individual is not being treatment concurrently with a biologic agent for the same or similar conditions (such as benralizumab, dupilumab, or mepolizumab; **AND**
3. Must be dosed in accordance with the FDA label.

IgE-MEDIATED FOOD ALLERGY

INITIAL APPROVAL STANDARD REVIEW for up to 6 months:
Authorization of 6 months may be granted for the reduction of IgE-mediated food allergy reactions when all of the following criteria are met:
1. Member is 1 year of age or older.
2. The diagnosis of IgE-mediated food allergy has been confirmed by either of the following:
    i. Pre-treatment allergen-specific IgE level greater than or equal to 6IU/mL.
    ii. Skin-prick test (SPC) with wheal diameter greater than or equal to 4mm.
3. Member has one of the following:
    i. A positive physician controlled oral food challenge (e.g., moderate to severe skin, respiratory, or gastrointestinal [GI] symptoms).
    ii. History of a systemic reaction to a food.
4. Member has a pre-treatment serum IgE level greater than or equal to 30 IU/mL.
5. Member will continue to follow a food-allergen avoidance diet.

CONTINUED APPROVAL for up to 1 year:
Authorization for 12 months may be granted for the reduction of IgE-mediated food allergy reactions when all of the following criteria are met:
1. Member is 1 year of age of older.
2. Member has achieved or maintained a positive clinical response to therapy as evidenced by a decrease in hypersensitivity (e.g., moderate to severe skin, respiratory or GI symptoms) to food-allergen.
3. Member will continue to maintain a food-allergen avoidance diet.

Policy Guidelines
The ERS/ATS definition of high doses of various inhaled glucocorticoids in relation to patient age (in mcg/day):

Age 6 to 12 years
Beclomethasone ≥ 320 (HFA MDI)
Budesonide ≥ 800 (MDI or DPI); (≥ 720 mcg/day of US labeled budesonide DPI)
Ciclesonide ≥ 160 (HFA MDI)
Fluticasone propionate ≥ 500 (HFA MDI or DPI); (≥ 440 mcg/day of US labeled fluticasone HFA MDI)
Mometasone ≥ 500 (DPI); (≥ 550 mcg/day of US labeled mometasone DPI)

Age >12 years
Beclomethasone ≥ 1000 (HFA MDI)
Budesonide ≥ 1600 (MDI or DPI) ;(≥ 1440 mcg/day of US labeled budesonide DPI)
Ciclesonide ≥ 320 (HFA MDI)
Fluticasone propionate ≥ 1000 (HFA MDI or DPI); (≥ 880 mcg/day of US labeled fluticasone HFA MDI)
Mometasone ≥ 800 (DPI); (≥ 880 mcg/day of US labeled mometasone DPI

Note: Designation of high doses is provided from manufacturers' recommendations where possible. Equivalent high doses may be expressed differently between countries and some products (e.g., beclomethasone) are available in multiple formulations with different dosing recommendations. Medication inserts should be carefully reviewed by the clinician for the equivalent high daily dosage.

Clinical skin manifestations of CSU (Zuberbier, 2018):

1. An area of central swelling of various size and shape, usually with surrounding erythema, although erythema may be difficult to appreciate on darker skin tones.
2. An itching sensation.
3. A fleeting time course for an individual lesion (usually 30 minutes to 24 hours) with the skin returning to normal without ecchymoses (while skin returns to normal, new lesions may be developing spontaneously at other sites).

Angioedema, if present, in urticaria patients is characterized by (Zuberbier, 2018):

1. A sudden, pronounced erythematous or skin colored swelling of the lower dermis and subcutis or mucous membranes.

2. Sometimes pain, rather than itch.
3. A resolution slower than that of wheals (can take up to 72 hours).

CSU potential tapering options, other appropriate tapers may also be considered (Khan, 2021):

1. Dose may be lowered from 300 mg to 150 mg and the interval between injections can be gradually lengthened. If an individual has no symptoms for a period of time on 150 mg every eight weeks, therapy can be considered for discontinuation.
2. Dose may be maintained at 300 mg and interval prolonged by one week per cycle. Therapy can be considered for discontinuation if the individual's disease remains controlled with eight-week intervals.

Dosing and Administration

Dosing per FDA Guidelines

Omalizumab is administered as a subcutaneous injection.

Please refer to FDA label for dosing.

Please refer to a separate policy on Site of Care or Site of Service Review (policy #2018030) for pharmacologic/biologic medications.

Does Not Meet Primary Coverage Criteria Or Is Investigational For Contracts Without Primary Coverage Criteria

Omalizumab, for any indication or circumstance not described above, including but not limited to the below listed indications, does not meet member benefit certificate primary coverage criteria that there be scientific evidence of effectiveness in improving health outcomes.

1. Acute asthma exacerbations
2. Acute bronchospasm
3. Status asthmaticus
4. For individuals with CSU who have a duration of therapy ≥ 2 years without continued outbreaks AND whom have documentation of a successful taper or cessation of therapy

For members with contracts without primary coverage criteria, omalizumab, for any indication or circumstance not described above, including but not limited to the below listed indications, is

considered **investigational**. **Investigational** services are specific contract exclusions in most member benefit certificates of coverage.

1. Acute asthma exacerbations
2. Acute bronchospasm
3. Status asthmaticus
4. For individuals with CSU who have a duration of therapy ≥ 2 years without continued outbreaks AND whom have documentation of a successful taper or cessation of therapy.