Pharmacy Policy Bulletin

Title:	Omalizumab (Xolair®)
Policy #:	Rx.01.249

Application of pharmacy policy is determined by benefits and contracts. Benefits may vary based on product line, group, or contract. Some medications may be subject to precertification, age, quantity, or formulary restrictions (ie limits on non-preferred drugs). Individual member benefits must be verified.

This pharmacy policy document describes the status of pharmaceutical information and/or technology at the time the document was developed. Since that time, new information relating to drug efficacy, interactions, contraindications, dosage, administration routes, safety, or FDA approval may have changed. This Pharmacy Policy will be regularly updated as scientific and medical literature becomes available. This information may include new FDA-approved indications, withdrawals, or other FDA alerts. This type of information is relevant not only when considering whether this policy should be updated, but also when applying it to current requests for coverage.

Members are advised to use participating pharmacies in order to receive the highest level of benefits.

Intent:

The intent of this policy is to communicate the medical necessity criteria for **Omalizumab (Xolair®)** as provided under the member's prescription drug benefit.

Description:

Asthma is a chronic respiratory condition characterized by reversible airway obstruction associated with airway hyperresponsiveness and airway inflammation. Generally, most asthma starts in childhood in relation to sensitization to common inhaled allergens, such as dust mites, animal dander and pollens. These allergens stimulate T helper type 2 cell proliferation and subsequently stimulate the release of inflammatory mediators IL-4, IL-5 and IL-13. These inflammatory mediators then cause inflammation in the airways, which left untreated can result in airway remodeling or thickening of the airway walls, ultimately leading to airway narrowing and airflow obstruction.

Nasal polyps are benign outgrowths of the nasal mucosa and are a type of inflammatory mucosal nasal obstructions. While benign, they can cause some symptoms, such as stuffiness or a blocked feeling in the nose, feelings of pressure in the face and trouble smelling. Polyp tissues have been found to have high levels of T helper type 2 cytokines IL-5 and IL-13, as well as high levels of histamine, which are all thought to have a function in pathogenesis of nasal polyps. Development of nasal polyps is often associated with asthma and also with adverse reactions to aspirin and other NSAIDS.

Chronic idiopathic urticaria is defined as the occurrence of wheals and/or angioedema for a total duration of six weeks or more. It is characterized by the appearance of itchy, red-colored papules, also known as urticaria, wheals or hives, which can appear on any part of the body. Angioedema also occurs in some patients, characterized by swelling around the lips, cheeks, periorbital areas of the face, extremities, and genitals. Pathogenesis of chronic idiopathic urticaria is not fully understood but is thought to involve the activation of mast cells and basophils.

Omalizumab inhibits the binding of IgE to the high-affinity IgE receptor FcεRI on the surface of mast cells, basophils, and dendritic cells, resulting in FcεRI down-regulation on these cells. In allergic asthmatics and those with nasal polyps, treatment with omalizumab inhibits IgE-mediated inflammation, as evidenced by reduced blood and tissue eosinophils and reduced inflammatory mediators, including IL-4, IL-5 and IL-13. The mechanism by which omalizumab improves symptoms of chronic idiopathic urticaria, however, is currently unknown.

Xolair® (omalizumab) is indicated for the treatment of asthma, nasal polyps and chronic idiopathic urticaria.

Policy:

Allergic asthma

INITIAL CRITERIA: Omalizumab (Xolair®) is approved when ALL of the following are met:

1. Submission of medical records (e.g., chart notes, lab values) confirming a diagnosis of moderate to severe persistent allergic asthma; and
2. Submission of documentation (e.g., chart notes, lab values) confirming a positive skin test or in vitro reactivity to a perennial aeroallergen; and

3. One of the following:
    a. Both of the following:
        i. Member is 12 years of age or older; and
        ii. Submission of documentation (e.g., chart notes, lab values) confirming pre- treatment serum immunoglobulin IgE level between 30 to 700 IU/mL; or
    b. Both of the following:
        i. Member is 6 years to less than 12 years of age; and
        ii. Submission of documentation (e.g., chart notes, lab values) confirming pre-treatment serum immunoglobulin IgE level between 30 to 1300 IU/mL; and
4. Paid claims or submission of documentation (e.g., chart notes) confirming that the member is currently being treated with one of the following unless there is a contraindication or intolerance to one of these medications:
    a. Both of the following:
        i. High dose inhaled corticosteroid (ICS) (e.g., greater than 500 mcg fluticasone propionate equivalent/day); and
        ii. Additional asthma controller medication (e.g., leukotriene receptor antagonist, long-acting beta-2 agonist [LABA], tiotropium); or
    b. One maximally -dosed combination ICS/ LABA product (e.g. Advair [fluticasone propionate/salmeterol], Breo Ellipta [fluticasone/vilanterol], etc.); and
5. Prescribed by or in consultation with one of the following:
    a. Pulmonologist; or
    b. Allergist/ immunologist; and
6. Treatment will be initiated in a healthcare setting with at least 3 doses administered under the supervision of a healthcare provider; and
7. No concurrent therapy with any other biologic agents; and
8. Dosing and frequency does not exceed maximum FDA recommendation for indication requested

Initial authorization duration: 2 years

REAUTHORIZATION CRITERIA: Omalizumab (Xolair®) is re-approved when ALL of the following are met:

1. Submission of documentation (e.g., chart notes) confirming a positive clinical response to therapy (e.g., reduction in exacerbations, improvement in forced expiratory volume in 1 second [FEV1], decreased use of rescue medications); and
2. Prescribed by or in consultation with one of the following:
    a. Pulmonologist; or
    b. Allergist/Immunologist; and
3. Paid claims or submission of documentation (e.g., chart notes) confirming that the member is currently being treated with one of the following unless there is a contraindication or intolerance to one of these medications:
    a. Both of the following:
        i. High dose inhaled corticosteroid (ICS) (e.g., greater than 500 mcg fluticasone propionate equivalent/day); and
        ii. Additional asthma controller medication (e.g., leukotriene receptor antagonist, long-acting beta-2 agonist [LABA], tiotropium); or
    b. One maximally dosed combination ICS/ LABA product (e.g., Advair [fluticasone propionate/salmeterol], Breo Ellipta [fluticasone/vilanterol], etc.); and
4. No concurrent therapy with any other biologic agents; and
5. Dosing and frequency does not exceed maximum FDA recommendation per indication requested

Reauthorization duration: 2 years

	DOSE
Adults and pediatric patients 6 years of age and older	75 to 375 mg every 2 or 4 weeks. Determine dose (mg) and dosing frequency by serum total IgE level, measured before the start of treatment, and body weight (kg). Refer to omalizumab (Xolair®) Prescribing Information for additional information.

Chronic Idiopathic Urticaria

INITIAL CRITERIA Omalizumab (Xolair®) is approved when ALL of the following are met:

1. Submission of medical records (e.g., chart notes, lab values) confirming a diagnosis of chronic idiopathic urticaria; and
2. Member is 12 years of age or older; and
3. Paid claims or submission of documentation (e.g., chart notes) confirming an inadequate response or inability to tolerate one second- generation antihistamine (e.g., desloratadine) at maximally tolerated dose in addition to ONE of the following:
    a. Substituting to a different second- generation antihistamine; or
    b. H2 antihistamine(e.g., famotidine); or
    c. Leukotriene receptor antagonist (e.g., montelukast); or
    d. Systemic corticosteroids; or
    e. cyclosporine; and
4. Paid claims or submission of documentation (e.g., chart notes) confirming that Xolair will be used concurrently with an H1 antihistamine, unless there is a contraindication or intolerance to H1 antihistamine; and
5. Prescribed by or in consultation with one of the following:
    a. Allergist/ immunologist; or
    b. Dermatologist; and
6. Treatment will be initiated in a healthcare setting with at least 3 doses administered under the supervision of a healthcare provider; and
7. No concurrent therapy with any other biologic agents; and
8. Dosing and frequency does not exceed maximum FDA recommendation for indication requested

Initial authorization duration: 2 years

REAUTHORIZATION CRITERIA: Omalizumab (Xolair®) is re-approved when ALL of the following are met:

1. Member's disease status has been re-evaluated since the last authorization to confirm the member's condition warrants continued treatment; and
2. Submission of documentation (e.g., chart notes) confirming that the member has experienced at least one of the following:
    a. Reduction in itching severity from baseline; or
    b. Reduction in the number of hives from baseline; and
3. Prescribed by or in consultation with one of the following:
    a. Dermatologist; or
    b. Allergist/Immunologist; and
4. No concurrent therapy with any other biologic agents; and
5. Dosing and frequency does not exceed maximum FDA recommendation for indication requested

Reauthorization duration: 2 years

	DOSE
Adults and pediatric patients 12 years of age and older	150 mg or 300 mg every 4 weeks.

Nasal Polyps

INITIAL CRITERIA: Omalizumab (Xolair®) is approved when ALL of the following are met:

1. Submission of medical records (e.g., chart notes, lab values) confirming a diagnosis of nasal polyps; and
2. Member has baseline serum IgE level of between 30 IU/mL and 1500 IU/mL; and
3. Paid claims or submission of documentation confirming an inadequate response or inability to tolerate at least a 2-month treatment with intranasal corticosteroid; and
4. Used in combination with another agent for nasal polyps (e.g., intranasal corticosteroid); and
5. Prescribed by or in consultation with one of the following:
    a. Allergist/Immunologist; or
    b. ENT specialist; or
    c. Pulmonologist; and

6. Treatment will be initiated in a healthcare setting with at least 3 doses administered under the supervision of a healthcare provider; and
7. No concurrent therapy with any other biologic agents; and
8. Dosing and frequency does not exceed maximum FDA recommendation for indication requested

Initial authorization duration: 2 years

REAUTHORIZATION CRITERIA: Omalizumab (Xolair®) is re-approved when ALL of the following are met:

1. Documentation of positive clinical response to therapy (e.g., reduction in nasal polyps score [NPS: 0-8 scale], improvement in nasal congestion/obstruction score [NCS: 0-3 scale]); and
2. Used in combination with another agent for nasal polyps (e.g., intranasal corticosteroid); and
3. Prescribed by or in consultation with one of the following:
    a. Allergist/immunologist; or
    b. ENT specialist; or
    c. Pulmonologist; and
4. No concurrent therapy with any other biologic agents; and
5. Dosing and frequency does not exceed maximum FDA recommendation for indication requested

Reauthorization duration: 2 years

	DOSE
Adults	75 to 600 mg every 2 or 4 weeks. Determine dose (mg) and dosing frequency by serum total IgE level, measured before the start of treatment, and body weight (kg). Refer to omalizumab (Xolair®) Prescribing Information for additional information.

Black Box Warning as shown in the drug Prescribing Information:

Anaphylaxis:

- Anaphylaxis presenting as bronchospasm, hypotension, syncope, urticaria, and/or angioedema of the throat or tongue, has been reported to occur after administration of XOLAIR. Anaphylaxis has occurred as early as after the first dose of XOLAIR, but also has occurred beyond 1 year after beginning regularly administered treatment.
- Because of the risk of anaphylaxis, initiate XOLAIR therapy in a healthcare setting and closely observe patients for an appropriate period of time after XOLAIR administration. Health care providers administering XOLAIR should be prepared to manage anaphylaxis which can be life-threatening.
- Inform patients of the signs and symptoms of anaphylaxis and instruct them to seek immediate medical care should symptoms occur. Selection of patients for self-administration of XOLAIR should be based on criteria to mitigate risk from anaphylaxis

Guidelines:

Refer to the specific manufacturer's prescribing information for administration and dosage details and any applicable Black Box warnings.

BENEFIT APPLICATION

Subject to the terms and conditions of the applicable benefit contract, the applicable drug(s) identified in this policy is (are) covered under the prescription drug benefits of the Company's products when the medical necessity criteria listed in this pharmacy policy are met. Any services that are experimental/investigational or cosmetic are benefit contract exclusions for all products of the Company.

References:

Xolair® (omalizumab) [prescribing information]. South San Francisco, CA: Genentech, inc.; March 2023. Available at: https://www.gene.com/download/pdf/xolair_prescribing.pdf. Accessed April 19, 2023.

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Saini S. Chronic spontaneous urticaria: clinical manifestations, diagnosis, pathogenesis, and natural history. UpToDate. November 2021. Available at: https://www.uptodate.com/contents/chronic-spontaneous-urticaria-clinical-manifestations-diagnosis-pathogenesis-and-natural-history. Accessed April 19, 2023.

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Applicable Drugs:

Inclusion of a drug in this table does not imply coverage. Eligibility, benefits, limitations, exclusions, precertification/referral requirements, provider contracts, and Company policies apply.

Brand Name	Generic Name
Xolair®	Omalizumab

Cross References:

Rx.01.33 Off Label Use

Policy Version Number:	4.00
P&T Approval Date:	March 16, 2023
Policy Effective Date:	July 01, 2023
Next Required Review Date:	March 16, 2024