Medical Policy

BlueCross BlueShield of Kansas
An independent licensee of the Blue Cross Blue Shield Association

Title: Xolair® (omalizumab)

- **Prime Therapeutics will review Prior Authorization requests.**

  Prior Authorization Form:
  http://www.bcbsks.com/CustomerService/Forms/pdf/PriorAuth-1304KS-XOLA.pdf

  Link to Drug List (Formulary):
  http://www.bcbsks.com/CustomerService/PrescriptionDrugs/drug_list.shtml

Professional
Original Effective Date: August 2003
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Current Effective Date: May 15, 2017

Institutional
Original Effective Date: October 6, 2008
Revision Date(s): December 1, 2011; April 2, 2012; June 7, 2013; October 4, 2013; August 15, 2014; June 1, 2015; April 15, 2016; January 1, 2017; May 15, 2017
Current Effective Date: May 15, 2017

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DESCRIPTION

The intent of the Xolair (omalizumab) Prior Authorization (PA) Criteria is to appropriately select patients for therapy according to product labeling and/or clinical guidelines and/or clinical studies while adhering to the dosing guidelines for age, weight, and pretreatment IgE levels (for allergic asthma) as recommended in FDA labeling. In addition to meeting the dosing parameters, (for allergic asthma), a positive allergen test is required along with documentation of previous therapy as outlined in the treatment steps for control of asthma symptoms in the National Asthma Education and Prevention Program (NAEPP) expert panel and the Global Initiative for Asthma (GINA) guidelines. For chronic urticaria, criteria requires a 6 month history of disease (consistent with requirements in clinical trials) with a history of hives and itching, and concurrent maximal tolerable therapy with a H1 antihistamine unless the patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to H1 antihistamine therapy. Other FDA approved indications must be within FDA labeled dosing guidelines. For renewal of therapy, all dosing parameters must continue to be met with omalizumab contributing to the improvement or maintenance of asthma or improvement of urticaria symptoms. Other FDA approved indications must be within FDA labeled dosing guidelines. Both initial and renewal criteria will require omalizumab will not be used in combination with an injectable IL-5 inhibitor indicated for asthma.

Target Agent

- **Xolair**® (omalizumab)

FDA Approved Indications and Dosage[1]

Agent	Indications* ^	Dose and administration
Xolair® (omalizumab)	Moderate to severe persistent asthma in patients 6 years of age and above whose symptoms are inadequately controlled with inhaled corticosteroids	75 mg to 375 mg is administered subcutaneously every 2-4 weeks. Determine the dose and dosing frequency using the patient's pretreatment serum IgE level and body weight
	Chronic idiopathic urticaria in patients 12 years of age and above who remain symptomatic despite H1 antihistamine treatment	150 or 300 mg by subcutaneous injection every 4 weeks.

* Omalizumab is not indicated for treatment of other allergic conditions, other forms of urticaria, relief of acute bronchospasms, or status asthmaticus.

^ Omalizumab has not been studied for use in combination with Cinqair (reslizumab) or Nucala (mepolizumab).

POLICY

Prior Authorization Criteria for Approval

A. Initial use of Xolair (omalizumab) will be approved when **ALL** of the following are met:

1. The patient does not have any FDA labeled contraindications to the requested agent.
   AND
2. The requested agent will not be used with an injectable IL-5 inhibitor indicated for asthma (e.g. Nucala, Cinqair)
   AND
3. The patient has ONE of the following diagnoses:
   a. Moderate to severe persistent asthma
      OR
   b. Chronic idiopathic urticaria
      OR
   c. The patient has another FDA approved diagnosis
   AND
4. If the diagnosis is moderate to severe persistent asthma, the patient meets **ALL** of the following:
   a. If the patient is 6 to less than 12 years of age, the patient meets BOTH of the following:
      i. The pretreatment IgE level is 30 IU/mL to 1300 IU/mL
         AND
      ii. The patient's weight is 20 kg to 150
      AND
   b. If the patient is 12 years of age and above, the patient meets ALL of the following:
      i. The pretreatment IgE level is 30 IU/mL to 700 IU/mL
         AND
      ii. The patient's weight provided for review of dose)is 30 kg to 150 kg
         AND
      iii. The patient has a baseline FEV_1 <80% predicted
   c. Allergic asthma has been confirmed by a positive skin test or in vitro reactivity test (RAST) to a perennial aeroallergen
      AND
   d. The patient has ONE of the following:
      i. Frequent severe asthma exacerbations requiring two or more courses of systemic corticosteroids (steroid burst) within the past 12 months
         OR

ii. Serious asthma exacerbations requiring hospitalization, mechanical ventilation, or visit to the emergency room or urgent care within the past 12 months
OR
iii. Controlled asthma that worsens when the doses of inhaled and/or systemic corticosteroids are tapered
AND

e. ONE of the following:
i. The patient is currently treated with a maximally tolerated inhaled corticosteroid
OR
ii. The patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to inhaled corticosteroids
AND

f. ONE of the following:
i. The patient is currently treated with ONE of the following:
1) A long-acting beta-2-agonist (LABA)
OR
2) A Leukotriene receptor antagonist (LRTA)
OR
3) Long-acting muscarinic antagonist (LAMA)
OR
4) Theophylline
OR
ii. The patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to long-acting beta 2-agonists (LABA), leukotriene receptor antagonist (LRTA), Long-acting muscarinic antagonist (LAMA), AND theophylline
AND

g. The requested dose is within dosing based on pre-treatment serum IgE level and the patient's body weight as defined in FDA approved labeling AND does not exceed 375 mg every 2 weeks
AND

5. If the diagnosis is chronic idiopathic urticaria, the patient meets **ALL** of the following:
a. The patient is 12 years of age or above
AND
b. The patient has a history of chronic idiopathic urticaria for at least 6 months
AND
c. The patient has a history of hives and itching
AND

d. ONE of the following:
   i. The patient is currently on maximally tolerated H1-antihistamine therapy
   OR
   ii. The patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to H1 antihistamine therapy

AND

e. The dose is within the FDA labeled dose not to exceed 300 mg every 4 weeks

AND

6. If another FDA approved diagnosis, the dosing is within the FDA approved dosing limit

Length of Approval: 24 weeks for asthma and chronic idiopathic urticaria
12 months for all other FDA approved indications

B. Continued use (renewal) of Xolair (omalizumab) will be approved when **ALL** of the following are met:

1. The patient has been previously approved for the requested agent through the PA process
   AND
2. The patient does not have any FDA labeled contraindications to the requested agent
   AND
3. The requested agent will not be used in combination with an injectable IL-5 inhibitor indicated for asthma (e.g. Nucala, Cinqair)
   AND
4. If the diagnosis is moderate to severe persistent asthma, the patient meets **ALL** of the following:
   a. The patient's weight is within the FDA indicated range for their age (i.e. 20 kg to 150 kg for patients age 6 to less than 12 years and 30 kg to 150 kg (for patients 12 years of age and above)
      AND
   b. The patient has had clinical response or disease stabilization as defined by ONE of the following:
      i. Increase in percent predicted FEV_1 from baseline
      OR
      ii. Decrease in the dose of inhaled corticosteroid required to control the patient's asthma
      OR
      iii. Decrease in need for treatment with systemic corticosteroids
      OR

iv. Decrease in number of hospitalizations, need for mechanical ventilation, or visits to the emergency room or urgent care due to exacerbations of asthma

AND

c. ONE of the following:
   i. The patient is currently treated and is compliant with standard therapy (e.g. inhaled corticosteroids, long acting beta-2 agonists (LABA), leukotriene receptor antagonists (LTRA), Long-acting muscarinic antagonist (LAMA), theophylline)

   OR

   ii. The patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to ALL standard therapies

AND

d. The dose is within dosing based-on pre-treatment serum IgE level and the patient's body weight as defined in FDA approved labeling AND does not exceed 375 mg every 2 weeks

AND

5. If the diagnosis is chronic idiopathic urticaria, the patient meets ALL of the following:
   a. Improvement in symptoms (e.g. number of hives, size of hives, reduction in itching)

   AND

   b. The dose is within the FDA labeled dose (i.e. 300 mg every 4 weeks)

Length of Approval: 12 months

Agent (s)	Contraindication(s)
Xolair® (omalizumab)	Severe hypersensitivity reaction to Xolair or any ingredient of Xolair

FDA Approved Dosing for Patients Age 6 to less than 12 Years

Pre-treatment Serum IgE (IU/mL)	Dosing Freq.	Body Weight									
		20-25 kg	>25-30 kg	>30-40 kg	>40-50 kg	>50-60 kg	>60-70 kg	>70-80 kg	>80-90 kg	>90-125 kg	>125-150 kg
		Dose (mg)									
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	DO NOT DOSE	
>400-500		225	300	225	225	300	300	375	375		
>500-600		300	300	225	300	300	375	DO NOT DOSE			
>600-700		300	225	225	300	375	DO NOT DOSE				
>700-800	Every 2 weeks	225	225	300	375	DO NOT DOSE					
>800-900		225	225	300	375						
>900-1000		225	300	375	DO NOT DOSE						
>1000-1100		225	300	375							
>1100-1200		300	300	DO NOT DOSE							
>1200-1300		300	375								

FDA-Approved Dosing for Patients 12 years of Age and Above

Pre-treatment serum IgE (IU/mL)	Body weight (kg)			
	30-60	> 60-70	> 70-90	> 90-150
≥ 30-100	150 mg q 4 wks	150 mg q 4 wks	150 mg q 4 wks	300 mg q 4 wks
> 100-200	300 mg q 4 wks	300 mg q 4 wks	300 mg q 4 wks	225 mg q 2 wks
> 200-300	300 mg q 4 wks	225 mg q 2 wks	225 mg q 2 wks	300 mg q 2 wks
> 300-400	225 mg q 2 wks	225 mg q 2 wks	300 mg q 2 wks	
> 400-500	300 mg q 2 wks	300 mg q 2 wks	375 mg q 2 wks	
> 500-600	300 mg q 2 wks	375 mg q 2 wks		
> 600-700	375 mg q 2 wks			

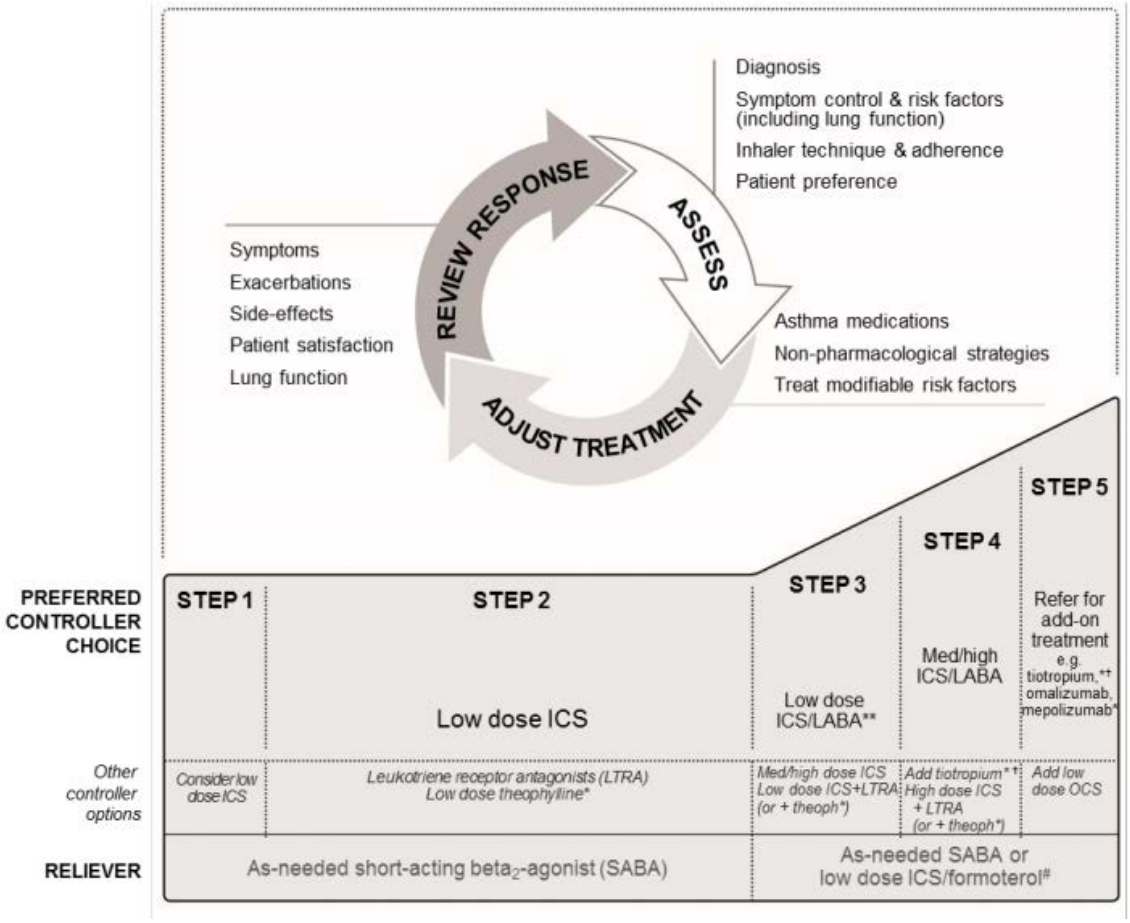
RATIONALE

Asthma

Asthma is a complex disorder characterized by variable and recurring clinical symptoms, airflow obstruction, bronchial hyperresponsiveness, and underlying inflammation.[2] Symptoms of asthma include wheezing, coughing, recurrent difficulty breathing, and chest tightness. Generally, these symptoms will occur or worsen with exposure to allergens and irritants, infections, exercise, changes in weather, stress, or menstrual cycles.[2] The National Asthma Education and Prevention Program (NAEPP) Expert Panel guidelines recommend the use of detailed medical history, physical examination, and spirometry to make a diagnosis of asthma. In addition, differential diagnosis of asthma should be considered. Once a definitive diagnosis of asthma is made, the goal of disease management is reduction of impairment from asthma and reduction of risk (i.e. prevent recurrent exacerbations, and systemic steroid bursts, prevent loss of lung function, and provide optimal pharmacotherapy).[2] The Global Initiative for Asthma (GINA) guidelines (updated

in 2016) and NAEPP Expert Panel guidelines recommend a stepwise approach for managing asthma.[2,3] Inhaled corticosteroids are considered the most effective long term therapy for control and management of asthma.[2] The patient's asthma can be considered to be well controlled when asthma symptoms are twice a week or less; the rescue bronchodilator medication is used twice a week or less; there is no nocturnal or early morning awaking due to asthma symptoms; there are no limitations of work, school, or exercise; and the Forced Expiratory Volume (FEV1) is normal or the patient's personal best.[6] Markers of asthma that is not adequately controlled in patients receiving therapy include limitation of normal activities, poor lung function with FEV1 of <80% predicted, at least 2 episodes per year of asthma exacerbations requiring oral systemic corticosteroids.[2] More frequent and intense exacerbations (e.g. requiring urgent, unscheduled care, hospitalization, or ICU admission) indicate poorer disease control.[4]

Figure 1: 2016 GINA Guidelines on Stepwise approach to treatment of Asthma



ICS-inhaled corticosteroid, LABA-long acting beta agonist, SABA-short acting beta agonist, LTRA-leukotriene receptor antagonist

* Not for children

** For children 6–11 years, the preferred Step 3 treatment is medium dose ICS

Low dose ICS/formoterol is the reliever medication for patients prescribed low dose budesonide/formoterol or low dose beclometasone/formoterol maintenance and reliever therapy.

†Tiotropium by mist inhaler is an add-on treatment for patients with a history of exacerbations; it is not indicated in children

Efficacy

Moderate to Severe Allergic (IgE-mediated) Asthma:

Omalizumab is indicated for moderate to severe allergic asthma. Allergic asthma is triggered by inhalation of allergens.[6] IgE is the antibody responsible for activation of allergic reactions and is important to the pathogenesis of allergic asthma and the development and persistence of inflammation. GINA guidelines define moderate asthma as that which is well controlled with low dose ICS in combination with a LABA.[3] Severe asthma is defined as "asthma that requires treatment with high dose inhaled corticosteroids (ICS) plus a second controller and/or systemic corticosteroids to prevent it from becoming 'uncontrolled' or which remains 'uncontrolled' despite this therapy."[4] Both GINA and NAEPP recommend use of omalizumab as add on therapy for patients who have failed to respond to standard therapy (refer to step 5 in figure 1 above) and have IgE-mediated allergic asthma.

Efficacy of omalizumab for the treatment of moderate to severe allergic asthma in patients 12 years of age and above was evaluated in three (trial 1, 2, and 3) randomized, double-blind, placebo controlled trials. Patients had to have had symptoms of moderate to severe asthma for at least 1 year prior to enrollment, a positive skin test reaction to at least one perennial aeroallergen, and serum IgE level of 30 to 700 IU/mL. Trial 1 and 2 demonstrated patients treated with omalizumab had fewer asthma exacerbations compared to placebo while trial 3 did not demonstrate a difference between the omalizumab and placebo groups. No reduction in asthma exacerbation was observed in trial 1, 2, and 3 among omalizumab treated patients who had an FEV1 >80%.

Efficacy of omalizumab in asthmatic children 6 to <12 years of age was established in two clinical trials: a double-blind, placebo controlled, trial (trial 4) and an additional supportive trial (trial 5). Trial 4 enrolled patients with a diagnosis of moderate to severe asthma for at least 1 year. The patients were also required to have had asthma exacerbation within a year prior to enrollment. The primary endpoint was rate of asthma exacerbations within the first 24 weeks of the trial. Patients treated with omalizumab had statistically significant lower rate of asthma exacerbations when compared to the placebo arm (0.45 vs. 064. RR 0.69. 95% CI:0.52, 0.90). There were no siginificant differenced in FEV1, nocturnal symptoms scores, and beta-agonist use between the omalizumab and placebo group.[1] Trial 5 was a 28 week, randomized, double blind, placebo-controlled study that included 298 patients who were 6 to less than 12 years of age. This trial demonstrated that patients treated with omalizumab had fewer asthma exacerbations compared to placebo.

Chronic Idiopathic Urticaria (CIU)

Chronic urticaria is a cutaneous mast cell degranulation lasting more than 6 weeks characterized by hives or wheals. The wheals usually last less than 24 hours with itching being the most common symptom. Diagnosis involves evaluation of labs including a complete blood count with differential, stool samples (assessing for parasitic activity), erythrocyte sedimentation rate, antinuclear antibody, hepatitis B and C titers, serum cryoglobulin and complement assays, thyroid function testing, and Chronic Urticaria index.

The standard of care is non-sedating antihistamines. Additional agents may be added on and/or substituted including leukotriene antagonists, systemic corticosteroids, immunomodulators, anti-inflammatory agents, and thyroid medications for patients who failed to respond to antihistamines.

The safety and efficacy of Xolair for the treatment of CIU was assessed in two placebo-controlled, multiple-dose clinical studies of 24 weeks' duration (CIU Study 1; n= 319) and 12 weeks' duration (CIU Study 2; n=322). Patients received omalizumab 75, 150, or 300 mg or placebo by SC injection every 4 weeks in addition to their baseline level of H1 antihistamine therapy for 24 or 12 weeks, followed by a 16-week washout observation period. A total of 640 patients (165 males, 475 females) were included for the efficacy analyses. [1]

Disease severity was measured by a weekly urticaria activity score (UAS7, range 0–42), which is a composite of the weekly itch severity score (range 0–21) and the weekly hive count score (range 0–21). In both CIU Studies 1 and 2, patients who received omalizumab 150 mg or 300 mg had greater decreases from baseline in weekly itch severity scores and weekly hive count scores than placebo at Week 12

The most common adverse events reported in patients 12 years and above with asthma were arthralgia, general pain, fatigue, dizziness, pruritus, dermatitis, and earache. Most common adverse events among pediatric patients treatment with omalizumab for asthma included nasopharyngitis, headache, pyrexia, abdominal pain, otitis media, and epistaxis. Omalizumab has a boxed warning due to risk of anaphylaxis. It is also contraindicated in patients with history of hypersensitivity to omalizumab or any ingredients of omalizumab.[1]

REVISIONS	
09-05-2008	Policy added to the bcbsks.com web site.
12-01-2011	Revised Title adding “omalizumab” to read “Xolair (omalizumab) Prior Authorization Criteria”
	Description section updated
	In Policy section: ▪ Wording revised from question format to statement format.
	Rationale section removed
	References section updated
04-02-2012	In Policy Section: ▪ In A 5, A 6, and A 7 removed, "medication history includes use of" and added "is currently using" to read: "5. The patient is currently using an inhaled corticosteroid..." "6. The patient is currently using a long-acting β_2-agonist..." "7. The patient is currently using a leukotriene modifier..." ▪ Revised wording in A 9 and B 5 from "The dose is within dosing parameters defined in product labeling OR does not exceed 375 mg every 2 weeks." to "a. The dose is within dosing parameters defined in product labeling OR b. If the recommended dose falls in the "Do Not Dose" range, Xolair will be approved at 375 mg every 2 weeks" ▪ For Section A. Initial use of Xolair, revised Length of Approval from "12 months" to "16 weeks". ▪ In Section B removed the following 3 criteria: "1. Patient is twelve years of age or older 2. The pretreatment IgE level $\geq$ 30 IU (level provided for review of dose) 4. Allergic asthma has been confirmed by skin testing or in vitro reactivity (RAST) testing" and added the following 2 criteria: "1. The patient has been previously approved for the requested therapy through the PA process

REVISIONS	
	3. The patient is currently on and compliant with standard therapy (such as a combination of an inhaled corticosteroid, long acting beta-2 agonist, leukotriene receptor antagonist, theophylline, oral corticosteroid or an oral beta-2 agonist tablet) OR the patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to ALL standard therapies" ▪ Revised chart title of "Xolair Dosing Administration" to "FDA Approved Dosing" ▪ Added "Do Not Dose" to the FDA Approved Dosing chart to clarify the policy intent.
	Rationale section added
	References updated
06-07-2013	Title updated from "Xolair® (omalizumab) Prior Authorization Criteria" to "Xolair® (omalizumab)"
	Description section updated to add FDA Approved Indications and Dosage, and Dosage Adjustment information
	Rationale section reviewed, no updates needed.
	Added Coding section ▪ Added HCPCS code: J2357
	References updated
10-04-2013	In Header: ▪ Link to updated Prior Authorization fax form added.
08-15-2014	Description section updated
	In Policy section: ▪ In Item A 2 clarified the indication of "a. The patient has a diagnosis of asthma OR" ▪ In Item A 2 added the indication of "b. The patient has a diagnosis of chronic idiopathic urticaria" ▪ Bundled criteria for asthma use under Item 3 ▪ In Item A 3 a added "but ≤700 IU" to read "The pretreatment IgE level 30 IU bu 700 IU (level provided for review of dose)" ▪ In Item A 3 b added "but ≤150 kg" to read "The patient's weight is 30 kg but ≤ (weight provided for review of dose)" ▪ In Item A 3 d added new criteria of "The patient has a baseline FEV1 <80% predicted" ▪ In Item A and B removed the wording "If the recommended dose falls in the "Do Not Dose" range, Xolair will be approved at 375 mg every 2 weeks" and added in Items A 4 b and B 2 d "or does not exceed 375 mg every 2 weeks" to read "The dose is within dosing parameters defined in product labeling or does not exceed 375 mg every 2 weeks" ▪ Added new indication of chronic idiopathic urticaria to read: "5. If chronic idiopathic urticaria, the patient meets ALL of the following: a. The patient has a history of chronic idiopathic urticaria for at least 6 months AND e. The patient has a history of hives and itching AND f. The patient is on maximum H1-antihistamine therapy AND d. The dose is within the FDA labeled dose not to exceed 300 mg every 4 weeks" ▪ In Item A Length of Approval add "for asthma" and "24 weeks for chronic idiopathic urticaria" ▪ In Item B removed "Continued use (renewal) of Xolair will be approved when ALL of:" and added "Renewal Evaluation: when" ▪ In Item B 2 a added "but ≤150 kg" to read "The patient's weight is 30 kg but (weight provided for review of dose)" ▪ In Item B 2 removed the wording of "Patient assessment indicates Xolair is contributing to improvement in asthma symptoms or maintenance of asthma control" ▪ Added new indication of chronic idiopathic urticaria to read: "3. If chronic idiopathic urticaria, the patient meets ALL of the following: a. Improvement in symptoms (e.g. number of hives, size of hives, reduction in itching)

REVISIONS	
	AND b. The dose is within the FDA labeled dose not to exceed 300 mg every 4 weeks" ▪ Updated the FDA Approved Dosing chart and added "for Asthma" to the chart title.
	Rationale section updated
	References updated
06-01-2015	Policy published 04-21-2015.
	Description section updated
	In Policy section: ▪ In Item A 2 added “The patient has another FDA labeled diagnosis” ▪ In Item A 3 h added “(pre-treatment serum IgE level and body weight)” ▪ In Item A 4 added “c. ONE of the following:” ▪ In Item A 4 c 1) added “currently” and “tolerable” to read “The patient is currently on maximum tolerable H1-antihistamine therapy OR” ▪ In Item A 4 c added “2) The patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to H1 antihistamine therapy” ▪ In Item A added the length of approval of: “12 months for all other FDA approved indications” ▪ In Item B revised “Renewal Evaluation: when ALL of the following are met:” to read “Continued use (renewal) of Xolair will be approved when ALL of the following are met:” ▪ In Item B 2 b added “OR” between 1), 2), 3) and 4). ▪ In Item B 2 added “c. ONE of the following:” ▪ In Item B 2 d added “(pre-treatment serum IgE level and body weight)” ▪ In Item B added “4. If another FDA approved diagnosis, the dosing is within the FDA approved dosing limit.”
	Rationale section updated
	Coding section removed
	References updated
04-15-2016	Description section updated to include adding Dosing Adjustment information
	In Policy section: ▪ In Item A added "(omalizumab)" to read "Initial use of Xolair (omalizumab)..." ▪ In Item A 1 moved to another section of the policy "Patient is twelve years of age or older" and added "The patient does not have any FDA labeled contraindications to the requested agent." ▪ Added Item 2 a "BOTH of the following" ▪ In Item 2 a i added "The patient has ONE of the following diagnoses:" ▪ In Item 2 a i 1) removed "The patient has a diagnosis of" and added "Moderate to severe persistent" to read "Moderate to severe persistent asthma" ▪ Added Item 2 a ii "The patient is twelve years of age or over" ▪ In Item 2 b removed "labeled" and added "approved" to read "The patient has another FDA approved diagnosis" ▪ In Item 3 added "diagnosis is moderate to severe persistent" to read "If the diagnosis is moderate to severe persistent asthma, the patient meets ALL of the following:" ▪ In Item 3 c added "a positive" and "to a perennial aeroallergen" to read "Allergic asthma has been confirmed by a positive skin test or in vitro reactivity test (RAST) to a perennial aeroallergen" ▪ Added Item 3 e: "e. The patient has ONE of the following: i. Frequent severe asthma exacerbations requiring two or more courses of systemic corticosteroids (steroid burst) within the past 12 months OR ii. Serious asthma exacerbations requiring hospitalization, mechanical ventilation, or visit to the emergency room or urgent care within the past 12 months OR

REVISIONS	
	iii. Controlled asthma that worsens when the doses of inhaled and/or systemic corticosteroids are tapered" ▪ Added Item 3 f "ONE of the following" ▪ In Item 3 f i removed "using an" and added "treated with a maximally tolerated" to read "The patient is currently treated with a maximally tolerated inhaled corticosteroid" ▪ In Item g i removed "using a" and added "treated with ONE of the following:" to read "The patient is currently treated with ONE of the following:" Added to Item g i: "2) A Leukotriene receptor antagonist (LRTA) OR 3) Long-acting muscarinic antagonist (LAMA) OR 4) Theophylline" ▪ In Item g ii added "(LABA), leukotriene receptor antagonist (LRTA), Long-acting muscarinic antagonist (LAMA), AND theophylline" to read "The patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to long-acting beta-2-agonists agonist (LABA), leukotriene receptor antagonist (LRTA), Long-acting muscarinic antagonist (LAMA), AND theophylline" ▪ Removed "The patient is experiencing exacerbations of asthma symptoms requiring increased inhaled corticosteroid dosing, increased daily use of beta-2-agonist rescue medication or systemic steroids" ▪ In Item 3 h removed "parameters" and "product" and added "requested", "based on", "the patient's", "FDA approved" and "(refer to Table 2) AND" to read "The requested dose is within dosing (based on pre-treatment serum IgE level and the patient's body weight) as defined in FDA approved labeling (refer to Table 2) AND does not exceed 375 mg every 2 weeks" ▪ In Item 4 added "the diagnosis is" to read "If the diagnosis is chronic idiopathic urticaria, the patient meets ALL of the following:" ▪ Added Item 5 "If another FDA approved diagnosis, the dosing is within the FDA approved dosing limit" ▪ In Item B added "(omalizumab)" to read "Continued use of Xolair (omalizumab)..." ▪ Added Item 2 "The patient does not have any FDA labeled contraindications to the requested agent" ▪ In Item 3 added " If the diagnosis is moderate to severe persistent" to read "If the diagnosis is moderate to severe persistent asthma, the patient meets ALL of the following:" ▪ In Item 3 b removed "does not have" and "worsening" and added "has had" and "response or disease stabilization as" to read "The patient has had clinical response or disease stabilization as defined by ONE of the following: ▪ Added Item 3 b i "Increase in percent predicted FEV1 from baseline" ▪ In Item 3 b ii removed "increase in" and "use" and added "Decrease in the does of" and "required to control the patient's asthma" to read "Decrease in the dose of inhaled corticosteroid required to control the patient's asthma" ▪ In Item 3 b iii added "Decrease in need for" to read "Decrease in need for treatment with systemic corticosteroids" ▪ In 3 b removed "Increased use of short acting beta-2-agonist rescue medication" ▪ In 3 b iv removed "Unscheduled care" and "ER, or hospitalizations)" and added "Decrease in number of hospitalizations, need for mechanical ventilation", "to the emergency room or", and "of asthma" to read "Decrease in number of hospitalizations, need for mechanical ventilation, or visits to the emergency room or urgent care due to exacerbations of asthma" ▪ In Item 3 c i removed "on", "such as a combination of an" and "oral corticosteroid or an oral beta 2 agonist tablet" and added "treated" and "(LTRA), Long-acting muscarinic antagonist (LAMA)" to read "The patient is currently treated and is compliant with standard therapy (e.g. inhaled corticosteroids, long acting beta-2 agonists (LABA), leukotriene receptor antagonists (LTRA), Long-acting muscarinic antagonist (LAMA) and theophylline"

REVISIONS	
	▪ In 3 d removed "parameters" and "product" and added "based-on", "FDA approved" and "(refer to Table 2 AND" to read "The dose is within dosing based-on pre-treatment serum IgE level and the patient's body weight as defined in FDA approved labeling (refer to Table 2) AND does not exceed 375 mg every 2 weeks" ▪ In Item 4 added "the diagnosis is" to read "If the diagnosis is chronic idiopathic urticaria, the patient meets ALL of the following:" ▪ In Item 4 b removed "not to exceed" and added "(i.e." to read "The dose is within the FDA labeled dose (i.e. 300 mg every 4 weeks)" ▪ Added Table 1 for Contraindications ▪ Added Table 2: FDA Approved Dosing based on pre-treatment IGE level and body weight
	Rationale section updated
	References updated
01-01-2017	Policy published 12-29-2016. Effective 01-01-2017.
	Description section updated to include replacing FDA Indication and Dosage information with an FDA Approved Indications and Dosage chart.
	Summary of Policy section updates: ✓Added Xolair's new FDA approved indication for treatment of moderate to severe asthma in patients 6 to less than 12 years of age. ✓Extended the initial duration of approval from 16 weeks to 24 weeks. This was due to the new FDA indication mentioned above. ✓Added requirement that Xolair will not be used in combination with an injectable IL-5 inhibitor indicated for asthma (e.g. Nucala) ▪ These updates resulted in the following policy language changes: Initial Use ▪ Added Item A 2 "The requested agent will not be used with an injectable IL-5 inhibitor indicated for asthma (e.g. Nucala, Cinqair)" ▪ Removed "The patient is twelve years of age or over" ▪ Added Item 4 a "If the patient is 6 to less than 12 years of age, the patient meets BOTH of the following:" ▪ In Item 4 a i added "to 1300 IU/mL" and removed "but ≤ 700 IU (level provided for review of dose)" to read "The pretreatment IgE level is 30 IU/mL to 1300 IU/mL" ▪ In Item 4 a ii added "20" and removed "≥ 30" and "(weight provided for review of dose) to read "The patient's weight is 20 kg to 150 kg" ▪ Added Item 4 b "If the patient is 12 years of age and above, the patient meets ALL of the following: i. The pretreatment IgE level is 30 IU/mL to 700 IU/mL AND ii. The patient's weight provided for review of dose)is 30 kg to 150 kg AND iii. The patient has a baseline FEV1 <80% predicted" ▪ In Item 5 c removed "The patient has a baseline FEV1 <80% predicted" ▪ In Item 5 removed "The patient is 12 years of age or above" ▪ In Length of Approval removed "16 weeks for asthma" and added "asthma and" to a separate length of approval phrase to read "24 weeks for asthma and chronic idiopathic urticaria" Continued Use (renewal) ▪ Added Item B 3 "The requested agent will not be used in combination with an injectable IL-5 inhibitor indicated for asthma (e.g. Nucala, Cinqair)" ▪ In Item 4 a removed "≥", "but ≤", "(weight provided for review of dose)" and added "within the FDA indicated range for their age (i.e. 20 kg to 150 kg for patients age 6 to less than 12 years and" and "(for patients 12 years of age and above)" to read "The patient's weight is within the FDA indicated range for their age (i.e. 20 kg to 150 kg for patients age 6 to less than 12 years and 30 kg to 150 kg (for patients 12 years of age and above)" ▪ Added Table titled "FDA Approved Dosing for Patients Age 6 to less than 12 Years"

REVISIONS	
	▪ Revised title to Pre-treatment Serum IgE and Body weight table to " FDA-Approved Dosing for Patient 12 years of Age and Above"
	Rationale section updated
	References updated
05-15-2017	Description section updated
	In Policy section: ▪ In Item B removed "If another FDA approved diagnosis, the dosing is within the FDA approved dosing limit." to clarify another FDA approved diagnosis is part of the initial criteria and not required in the renewal criteria.
	Rationale section updated
	References updated

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