GCHP Medi-Cal Clinical Guidelines
Reslizumab (Cinqair™)

PA Criteria	Criteria Details
Covered Uses (FDA Approved Indication)	Add-on maintenance treatment of severe asthma with an eosinophilic phenotype.
Exclusion Criteria	• Treatment of other eosinophilic conditions or for the relief of acute bronchospasm or status asthmaticus. • Monotherapy use (reslizumab is add on therapy to the current asthma treatment regimen). • Reslizumab will not be used concurrently with other monoclonal antibodies with similar indications such as dupilumab, mepolizumab, omalizumab, tezepelumab or benralizumab.
Required Medical Information	**Initial:** Severe asthma with an eosinophilic type defined as all of the following: 1. Severe asthma as defined by symptoms that are persistent and uncontrolled on a. High-dose inhaled corticosteroids combined AND b. A long-acting beta2-agonist, leukotriene receptor agonist, or theophylline for at least 12 months of therapy OR the use of systemic glucocorticoids for greater than or equal to 50% of the previous year. 2. Persistent uncontrolled asthma as defined by at least one of the following: a. An ACQ (Asthma Control Questionnaire) score consistently higher than 1.5 or an ACT (Asthma Control Test) score lower than 20 b. 2 or more exacerbations in the past 12 months, each requiring three or more days of treatment with systemic glucocorticoids c. A history of hospitalization, intensive care unit stay, or mechanical ventilation in the past 12 months d. A FEV1 (Forced Expiratory Volume in one second) at less than 80% of predicted after bronchodilator administration measured by pulmonary function testing or spirometry a documented report and interpretation. 3. Eosinophilia as defined by a blood eosinophil count of greater than or equal to 400 cells / microliter at the initiation of therapy and documented by laboratory report (in the absence of other causes of eosinophilia such as a documented or suspected parasitic infection, neoplastic disease, or hyper-eosinophilic syndromes, etc.) 4. State the specific dose to be administered and frequency and the patient's current weight.

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<tr><td></td><td>Renewal: documentation of improvement by clinical measurements such as FEV1, asthma control questionnaire, the decreased use of beta-agonists, a decreased incidence of hospitalization, intensive care, or mechanical ventilation, etc.</td></tr>
<tr><td>Age Restriction</td><td>18 years of age and older</td></tr>
<tr><td>Prescriber Restrictions</td><td>Must be prescribed by or in consultation with a pulmonologist, allergist or immunologist.</td></tr>
<tr><td>Coverage Duration</td><td>12 months</td></tr>
<tr><td>Other Criteria</td><td>Criteria adapted from DHCS March 2024
<table>
<tr><th>HCPCS</th><th>Description</th><th>Dosing, Units</th></tr>
<tr><td rowspan="2">J2786</td><td rowspan="2">Injection, reslizumab, 1mg (Cinquair™)</td><td>• Recommended dose: 3mg/kg IV once every four weeks
• Administered as 210 mg subcutaneously once every four weeks</td></tr>
<tr><td>1 HCPCS unit = 1 mg</td></tr>
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STATUS	DATE REVISED	REVIEW DATE	APPROVED / REVIEWED BY	EFFECTIVE DATE
Created	5/1/2024	5/1/2024	Lily Yip, Director of Pharmacy Services; Yoonhee Kim, Clinical Programs Pharmacist	N/A
Approved	N/A	5/15/2024	Pharmacy & Therapeutics (P&T) Committee	3/1/2025
Approved	N/A	7/18/2024	Medical Advisory Committee (MAC)	3/1/2025