**Original Effective Date: 10/26/2011**
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**Policy Number: C5678-A**

# Xolair (omalizumab)

## PRODUCTS AFFECTED

Xolair (omalizumab)

## COVERAGE POLICY

*Coverage for services, procedures, medical devices and drugs are dependent upon benefit eligibility as outlined in the member's specific benefit plan. This Coverage Guideline must be read in its entirety to determine coverage eligibility, if any. This Coverage Guideline provides information related to coverage determinations only and does not imply that a service or treatment is clinically appropriate or inappropriate. The provider and the member are responsible for all decisions regarding the appropriateness of care. Providers should provide Molina Healthcare complete medical rationale when requesting any exceptions to these guidelines.*

***Documentation Requirements:***
*Molina Healthcare reserves the right to require that additional documentation be made available as part of its coverage determination; quality improvement; and fraud; waste and abuse prevention processes. Documentation required may include, but is not limited to, patient records, test results and credentials of the provider ordering or performing a drug or service. Molina Healthcare may deny reimbursement or take additional appropriate action if the documentation provided does not support the initial determination that the drugs or services were medically necessary, not investigational, or experimental, and otherwise within the scope of benefits afforded to the member, and/or the documentation demonstrates a pattern of billing or other practice that is inappropriate or excessive.*

**DIAGNOSIS:**
Chronic spontaneous urticaria, Moderate to severe persistent asthma, Nasal polyps, Food allergy

**REQUIRED MEDICAL INFORMATION:**
This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. If a drug within this policy receives an updated FDA label within the last 180 days, medical necessity for the member will be reviewed using the updated FDA label information along with state and federal requirements, benefit being administered and formulary preferencing. Coverage will be determined on a case-by-case basis until the criteria can be updated through Molina Healthcare, Inc. clinical governance. Additional information may be required on a case-by-case basis to allow for adequate review. When the requested drug product for coverage is dosed by weight, body surface area or other member specific measurement, this data element is required as part of the medical necessity review. The Pharmacy and Therapeutics Committee has determined that the drug benefit shall be a mandatory generic and that generic drugs will be dispensed whenever available.

A. CHRONIC SPONTANEOUS URTICARIA:
1. Diagnosis of Chronic Spontaneous Urticaria (CSU) documented by the presence of urticaria (hives) that has been continuously or intermittently present for more than 6 weeks
AND
2. Documented baseline score from an objective clinical evaluation tool [e.g., Urticaria Control Test (UCT), Urticaria Activity Score (UAS7), Angioedema Activity Score (AAS), Dermatology

Life Quality Index (DLQI), Angioedema Quality of Life (AE-QoL), or Chronic Urticaria Quality of Life Questionnaire (CU-Q2oL)] [DOCUMENTATION REQUIRED] AND

3. Documentation that member continues to experience hives associated with itching despite adequate, adherent trials (minimum 2 weeks) of ALL of the following treatments (See Appendix 6) *(Reference: AAAAI/ACAAI guideline on diagnosis and management acute and chronic urticaria [J Allergy Clin Immunol 2014 May;133(5):1270] see BACKGROUND)* [DOCUMENTATION REQUIRED of trial/failure with dates of therapy]:
   (a) Two different H1-antihistamines at the maximally tolerated doses (up to 4 times standard daily dose), unless medically contraindicated as monotherapy
   *MOLINA REVIEWER NOTE: If denying for prior utilization at high doses, please enter override for antihistamine quantity limits*
   AND
   (b) One H1-antihistamine IN COMBINATION with leukotriene receptor antagonist (LTRA) at the maximally tolerated doses (up to 4 times standard daily dose), unless medically contraindicated
   AND
   (c) One H1-antihistamine at the maximally tolerated doses (up to 4 times standard daily dose) in combination with ANY of the following: H2-Antihistamines OR an anti- inflammatory agent (e.g., dapsone, hydroxychloroquine, sulfasalazine) OR an immunosuppressant agent (e.g., cyclosporine, mycophenolate), unless medically contraindicated

B. MODERATE-TO-SEVERE PERSISTENT ALLERGIC ASTHMA:

1. Documented diagnosis of moderate to severe persistent asthma
   AND
2. Xolair (omalizumab) is NOT being used as monotherapy for asthma (must be prescribed as add-on maintenance to be used in combination with other medications for long-term control of asthma)
   AND
3. Documented pre-treatment serum total IgE levels (measured prior to start of treatment) greater than or equal to 30 IU/mL and less than or equal to 1500 IU/mL [DOCUMENTATION REQUIRED]
   AND
4. Documentation member has experienced exacerbation(s) or hospitalization(s), within the last 12 months as evidenced by ANY of the following [DOCUMENTATION REQUIRED]:
   i. Two or more exacerbations requiring treatment with systemic corticosteroid (intramuscular, intravenous, or oral) despite the use of high-dose inhaled corticosteroids in the past 12 months
   ii. One or more exacerbation requiring hospitalization in the past 12 months
   iii. Two-fold increase or greater in the dose of systemic corticosteroid treatment for asthma exacerbations
   iv. Asthma worsens upon tapering of oral corticosteroid therapy
   v. Mechanical ventilation in the past 12 months
   vi. Poor symptom control indicated by Asthma Control Questionnaire (ACQ) score consistently greater than 1.5 or Asthma Control Test (ACT) score consistently less than 20
   vii. Forced expiratory volume in 1 second (FEV1) < 80% predicted
   viii. FEV1/forced vital capacity (FVC) < 0.80
   AND
5. Documentation of adherence to ONE of the following regimens of at least 3 months (within the past 90 days) and symptoms inadequately controlled (as documented in criteria above):
   (a) Medium or High dose ICS- LABA combination product AND one additional asthma controller medication (LAMA, LTRA, Low dose azithromycin), preferably a LAMA- per GINA guideline
   OR
   (b) Medium or High dose ICS- LABA combination product AND oral corticosteroids [see appendix for product classes]

*MOLINA REVIEWER NOTE: Verify pharmacy claims for adherence with the combination therapy above within the last 90 days. For new members to Molina Healthcare, confirm medication use in medical chart history. Non-adherence, which can be documented by review of the prescription fill history, would not constitute therapeutic failure.*

C. CHRONIC RHINOSINUSITIS WITH NASAL POLYPS:
1. Documented diagnosis of chronic rhinosinusitis with nasal polyposis
   AND
2. member has a history of sino-nasal surgery or is not eligible for surgery
   AND
3. Documentation member has experienced an inadequate response (after 3 consistent months of use) or serious side effects to ONE of the following medications unless contraindicated: preferred formulary/PDL intranasal steroids OR preferred formulary/PDL oral corticosteroids
   AND
4. Documentation member is concurrently receiving treatment with one of the following agents: Intranasal steroids, Oral corticosteroids, Nasal saline irrigations, Antibiotics, or antileukotriene agents (i.e., not to be used as monotherapy)
   AND
5. Documentation of prescriber baseline disease activity evaluation and goals for treatment to be used to evaluate efficacy of therapy at renewal (e.g., nasal congestion, loss of smell, sino-nasal symptoms) [DOCUMENTATION REQUIRED]

D. FOOD ALLERGIES:
1. Documented diagnosis of food allergy (e.g., peanut, milk, egg, wheat, cashew, hazelnut, walnut)
   AND
2. Documentation of confirmation of an IgE mediated food allergy from a positive skin test or specific IgE or total serum IgE
   AND
3. Documented pre-treatment serum total IgE levels (measured prior to start of treatment) [DOCUMENTATION REQUIRED]
   AND
4. Documentation of baseline systemic allergic reactions requiring treatment and member has a history of at least 1 systemic allergic reaction requiring hospitalization, an ER visit, or use of injectable epinephrine
   NOTE: Continuation of therapy request requires follow-up documentation as evidence of positive benefit from therapy
   AND
5. Prescriber attests that member will use Xolair in conjunction with an allergen avoidant diet
   AND
6. Member has a current prescription for epinephrine and access to an epinephrine autoinjector while using Xolair (Review Rx history)
   AND
7. Prescriber attests or clinical reviewer has found member has NOT experienced severe or life-threatening episode of anaphylaxis or anaphylactic shock to the member specific foods (i.e., neurological compromise, intubation)
   AND
8. Documentation of medical justification which supports necessity for immunotherapy despite avoidance diet (e.g., member has a severe allergy that can be triggered by smell)

**CONTINUATION OF THERAPY:**

A. FOR ALL INDICATIONS:
1. Adherence to therapy at least 85% of the time as verified by the prescriber or member medication fill history OR adherence less than 85% of the time due to the need for surgery or treatment of an

infection, causing temporary discontinuation
AND

2. Prescriber attests to or clinical reviewer has found no evidence of intolerable adverse effects or drug toxicity (e.g. symptoms of anaphylaxis (bronchospasm, hypotension, syncope, urticaria, and/or angioedema), malignancy, symptoms similar to serum sickness (fever, arthralgia, and rash); parasitic (helminth) infection, eosinophilic conditions (e.g. vasculitic rash, worsening pulmonary symptoms, cardiac complications, and/ or neuropathy), especially upon reduction of oral corticosteroids)

B. CHRONIC SPONTANEOUS URTICARIA:

1. Documentation of positive clinical response as demonstrated by improvement from baseline using objective clinical evaluation tools [e.g., Urticaria Control Test (UCT), Urticaria Activity Score (UAS7), Angioedema Activity Score (AAS), Dermatology Life Quality Index (DLQI), Angioedema Quality of Life (AE- QoL), or Chronic Urticaria Quality of Life Questionnaire (CU-Q2oL)]. [DOCUMENTATION REQUIRED]

C. MODERATE-TO-SEVERE PERSISTENT ALLERGIC ASTHMA:

1. Documentation of positive clinical response as documented by ONE or more of the following from baseline [DOCUMENTATION REQUIRED]:
    a. Improvement in lung function (increase in percent predicted FEV1 or PEF)
    b. Decreased utilization of rescue medications
    c. Decreased frequency of exacerbations (defined as worsening of asthma that requires increase in inhaled corticosteroid dose or treatment with systemic corticosteroids)
    d. Decreased frequency of unscheduled clinic, urgent care or emergency department visits
    e. Reduction in reported symptoms: chest tightness, coughing, shortness of breath, nocturnal wakening wheezing, sustained improvement in Asthma Control Test (ACT) scores
    f. Decreased or stopped oral treatments (including oral corticosteroids and other add on medications, if applicable), or reduced ICS- LABA dose (to at least moderate)
    g. Reduction in severity or frequency of asthma-related symptoms (e.g., wheezing/heavy breathing, coughing, chest tightness or heaviness shortness of breath, sleep disturbance, night wakening, fatigue, or asthmatic symptoms upon awakening)

   MOLINA REVIEWER NOTE: For members with unclear response after initial use, see Background (GINA 2025).
   AND
2. Documentation member is currently treated and is compliant with standard therapy (e.g., inhaled corticosteroids, long-acting beta-2 agonist (LABA), leukotriene receptor antagonist (LTRA), long-acting muscarinic antagonist (LAMA)) within the past 90 days

D. NASAL POLYPS:

1. Documentation of positive clinical response as demonstrated by low disease activity and/or improvements in the condition's signs and symptoms (e.g., nasal congestion, loss of smell, sino-nasal symptoms) [DOCUMENTATION REQUIRED]
   AND
2. Prescriber attests or clinical reviewer has found that member continues on standard therapy (intranasal steroids, oral corticosteroids, nasal saline irrigations, antibiotics, or antileukotriene agents)

E. FOOD ALLERGIES:

1. Documentation of member re-assessment for this condition to determine if continuation of treatment with requested medication is medically necessary
   AND
2. Documentation of positive clinical response as documented by at least ONE of the following compared to pre-treatment to evaluate effectiveness:

a. Reduction in severe allergic reactions
b. Reduction in epinephrine use
c. Reduction in physician/clinic visits due to food allergy (physician office/ER visits/hospitalizations)
d. Improvement in quality of life or productivity

**DURATION OF APPROVAL**:
Initial authorization: 6 months, Continuation of therapy: 12 months

**PRESCRIBER REQUIREMENTS:**
Prescribed by, or in consultation with, a board-certified asthma specialist (allergist, immunologist, pulmonologist), or physician experienced in the management of asthma, allergist, immunologist, dermatologist, or otorhinolaryngologist. [If prescribed in consultation, consultation notes must be submitted with initial request and reauthorization requests]

**AGE RESTRICTIONS:**
Chronic spontaneous urticaria: 12 years of age and older
Asthma: 6 years of age and older
Nasal polyposis:18 years of age and older
Food allergy: 1 year of age and older

**QUANTITY:**
*Options for dosing quantity limits:*
Dose (75mg) = 1 x 75mg syringe ONLY
Dose (150mg) = 1 x 150mg syringe OR 150mg vial
Dose (225mg) = 1 x 75mg syringe + 1x 150mg syringe ONLY
Dose (300mg) = 2 x 150mg syringe OR 2 x 150mg vials
Dose (375mg) = 1 x 75mg syringe + 2 x 150mg syringe/vial Dose (450mg) = 3 x 150mg syringe OR 3 x 150mg vial
Dose (525mg) = 1 x 75mg syringe + 3 x 150mg syringe/vial
Dose (600mg) = 4 x 150mg syringe/vial

For Chronic Spontaneous Urticaria: MAX 300 mg every 4 weeks (dosing not dependent on serum IgE or body weight)
For Asthma: MAX 375 mg every 2 weeks, with dosing determined by serum IgE level (IU/mL) measured before the start of treatment, and body weight
For Nasal polyps: MAX 600 mg every 2 weeks, with dosing determined by serum IgE level (IU/mL) measured before the start of treatment, and body weight
For Food allergies: MAX 600 mg every 2 weeks, with dosing determined by serum IgE level (IU/mL) measured before the start of treatment, and body weight

**Maximum Quantity Limits –** Based on FDA labeled indication, weight, and IgE level

**PLACE OF ADMINISTRATION:**
The recommendation is that injectable medications in this policy will be for pharmacy or medical benefit coverage and the subcutaneous injectable products administered in a place of service that is a non- hospital facility-based location as per the Molina Health Care Site of Care program.

**Note:** Site of Care Utilization Management Policy applies for Xolair (omalizumab). For information on site of care, see Specialty Medication Administration Site of Care Coverage Criteria (molinamarketplace.com)

## DRUG INFORMATION

**ROUTE OF ADMINISTRATION:**

**DRUG CLASS:**
Anti-IgE Monoclonal Antibody

**FDA-APPROVED USES:**
Indicated for:

- Moderate to severe persistent asthma in adults and pediatric patients 6 years of age and older with a positive skin test or in vitro reactivity to a perennial aeroallergen and symptoms that are inadequately controlled with inhaled corticosteroids
  *Limitations of use: Not indicated for acute bronchospasm or status asthmaticus*
- Chronic rhinosinusitis with nasal polyps (CRSwNP) in adult patients 18 years of age and older with inadequate response to nasal corticosteroids, as add-on maintenance treatment
- IgE-mediated food allergy in adult and pediatric patients aged 1 year and older for the reduction of allergic reactions (Type I), including anaphylaxis, that may occur with accidental exposure to one or more foods. To be used in conjunction with food allergen avoidance
  *Limitations of use: Not indicated for the emergency treatment of allergic reactions, including anaphylaxis*
- Chronic spontaneous urticaria (CSU) in adults and adolescents 12 years of age and older who remain symptomatic despite H1 antihistamine treatment
  *Limitations of use: Not indicated for other forms of urticaria*

**COMPENDIAL APPROVED OFF-LABELED USES:**
None

## APPENDIX

**APPENDIX 1:**

Controller medications: suppress the inflammatory causes of asthma to provide clinical control over the long term, whereas reliever medications relieve bronchoconstriction quickly. Controller medications include inhaled glucocorticoids, long-acting beta-agonists (LABAs) and Leukotriene receptor antagonists (LTRA). Theophylline (Theo-24, Uniphyl, TheoChron ER, generics) is also a controller agent, however, it is not as efficacious as LABAs and not recommended for treatment.

**Anticholinergic (LAMA)**
Tiotropium bromide monohydrate (Spiriva Respimat)

**Inhaled Corticosteroids (ICS) (list not all inclusive):**
*Beclometasone dipropionate (QVAR)*
*Budesonide DPI (Pulmicort Flexhaler)*
*Budesonide nebules (Pulmicort Respules)*
*Ciclesonide (Alvesco)*
*Fluticasone propionate (ArmonAir Digihaler)*
*Flunisolide (Aerospan)*
*Mometasone furoate (Asmanex Twisthaler)*
*Mometasone furoate (Asmanex HFA*)*
*Fluticasone furoate (Arnuity Ellipta)*
*Fluticasone propionate (Flovent Diskus)*
*Fluticasone propionate (Flovent HFA)*

**HFA: hydrofluoroalkane propellant metered dose inhaler*
**DPI: dry powder inhaler*

**Combination Long-Acting Bronchodilator and Corticosteroid (ICS+ LABA) (list not all inclusive):**
*Budesonide/formoterol fumarate dihydrate (Symbicort)*
*Fluticasone propionate/salmeterol (Advair Diskus/ Adair HFA/ AirDuo/ AirDuo RespiClick/Wixela Inhub)*
*Fluticasone furoate/vilanterol(Breo Ellipta)*
*Mometasone furoate/formoterol fumarate dihydrate (Dulera)*

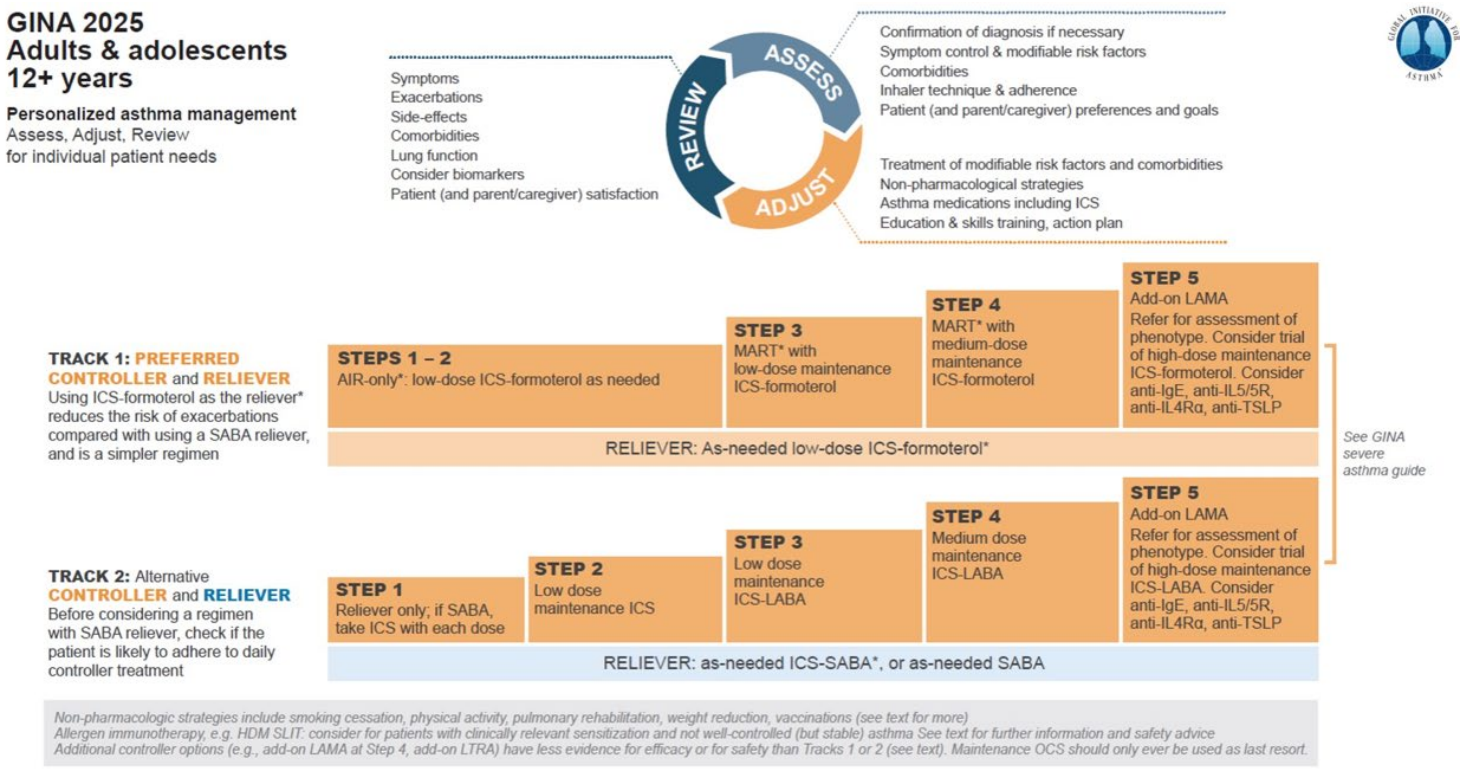
**Combination Anticholinergic and Corticosteroid and long-acting bronchodilator (ICS+ LAMA+ LABA)**
Fluticasone/umeclidnium/vilanterol (Trelegy Elipta)
Budesonide/glycopyrrolate/formoterol (Breztri Aerosphere)

**Leukotriene receptor antagonist (LTRA) (list not all inclusive):**
*Montelukast (Singulair), Zafirlukast (Accolate), Zileuton (Zyflo)*

**APPENDIX 2:**

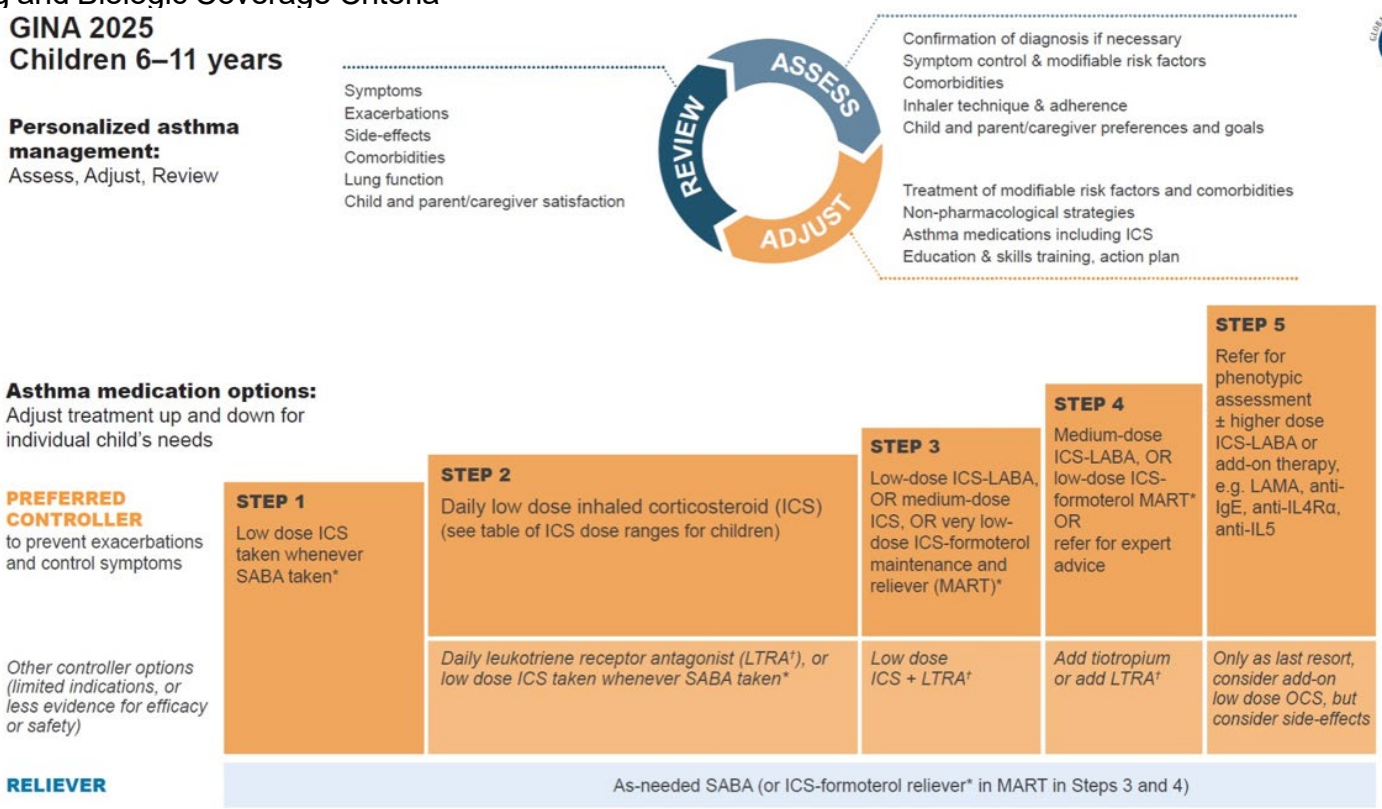
- FEV1 (forced expiratory volume in 1 second): A measure of airway obstruction determined using spirometry. Individual FEV1 values are compared to predicted values based on age, height, sex and race.
- PEF (peak expiratory flow): PEF is often described as a percent of personal best measurement. Personal best PEF is the highest PEF value attained after 2 to 3weeks of testing when asthma is in good control.

**APPENDIX 3: Managing Asthma in Adults and Adolescents 12+ Years**




ABBREVIATIONS: AIR: anti-inflammatory reliever; HDM: house dust mite; ICS: inhaled corticosteroid; Ig: immunoglobulin; IL: interleukin; LABA: long-acting beta2-agonist; LAMA: long-acting muscarinic antagonist; LTRA: Leukotriene Receptor Antagonist; MART: maintenance-and-reliever therapy with ICS-formoterol; OCS: oral corticosteroids; SABA: short-acting beta2-agonist; SLIT: sublingual immunotherapy; TSLP: thymic stromal lymphopoietin
REFERENCE: Global Initiative for Asthma. Global Strategy for Asthma Management and Prevention, 2025. Available from: www.ginasthma.org

**Managing Asthma in Children 6-11 Years**




ABBREVIATIONS: ICS: inhaled corticosteroid; Ig: immunoglobulin; IL: interleukin; LABA: long-acting beta2-agonist; LTRA: Leukotriene Receptor Antagonist (advise about risk of neuropsychiatric adverse effects); MART: maintenance and reliever therapy with ICS-formoterol; OCS: oral corticosteroids; SABA: short-acting beta2-agonist

REFERENCE: Global Initiative for Asthma. Global Strategy for Asthma Management and Prevention, 2025. Available from: www.ginasthma.org

**APPENDIX 4: SUGGESTED TOTAL DAILY DOSAGES for INHALED CORTICOSTEROIDS (ICS) IN ADULTS AND ADOLESCENTS (12 years and older):**

| Inhaled Corticosteroid | Low Dose ICS (mcg) | Medium Dose ICS (mcg) | High Dose ICS (mcg) |
|---|---|---|---|
| Beclometasone dipropionate (pMDI, standard particle, HFA) | 200-500 | >500-1000 | >1000 |
| Beclometasone dipropionate (DPI or pMDI, extrafine particle, HFA) | 100-200 | >200-400 | >400 |
| Budesonide (DIP, or pMDI, standard particle, HFA) | 200-400 | >400-800 | >800 |
| Ciclesonide (pMDI, extrafine particle, HFA) | 80-160 | >160-320 | >320 |
| Fluticasone furoate (DPI) | 100 | 100-200 | 200 |
| Fluticasone propionate (DPI) | 100-250 | >250-500 | >500 |
| Fluticasone propionate (pMDI, standard particle, HFA) | 100-250 | >250-500 | >500 |
| Mometasone furoate (DPI) | Depends on DPI device – see product information | | |
| Mometasone furoate (pMDI, standard particle, HFA) | 200-400 | 200-400 | >400 |

*Reference: Box 4-2. Low, medium and high daily metered doses of inhaled corticosteroids (alone or with LABA) Global Initiative for Asthma. Global Strategy for Asthma Management and Prevention, 2025. Available from: www.ginasthma.org*

**SUGGESTED TOTAL DAILY DOSAGES for INHALED CORTICOSTEROIDS (ICS) IN CHILDREN 6-11 YEARS:**

| Inhaled Corticosteroid | Low Dose ICS (mcg) | Medium Dose ICS (mcg) | High Dose ICS (mcg) |
|---|---|---|---|
| Beclometasone dipropionate (pMDI, standard particle, HFA) | 100-200 | >200-400 | >400 |
| Beclometasone dipropionate (pMDI, standard particle, HFA) | 50-100 | >100-200 | >200 |
| Budesonide (DPI, or pMDI, standard particle, HFA) | 100-200 | >200-400 | >400 |
| Budesonide (nebules) | 250-500 | >500-1000 | >1000 |
| Ciclesonide (pMDI, extrafine particle, HFA) | 80 | >80-160 | >160 |
| Fluticasone furoate (DPI) | 50 | 50 | NA |
| Fluticasone propionate (DPI) | 50-100 | >100-200 | >200 |
| Fluticasone propionate (pMDI, standard particle, HFA) | 50-100 | >100-200 | >200 |
| Mometasone furoate (pMDI, standard particle, HFA) | 100 | 100 | 200 |

*Reference: Box 4-2 . Low, medium and high daily metered doses of inhaled corticosteroids (alone or with LABA) Global Initiative for Asthma. Global Strategy for Asthma Management and Prevention, 2025. Available from: www.ginasthma.org*

**APPENDIX 5:**
Dermatology Life Quality Index (DLQI): A self-administered 10-item questionnaire that rates the impact of skin disease on symptoms and feelings, daily activities, leisure, work and school, personal relationships, and treatment. The average completion time of 2 minutes. The DLQI may be used for routine clinical use by clinicians in order to assist the clinical consultation, member evaluation and monitoring and to help with clinical decision-making process.

Urticaria Activity Score (UAS): A member reported CIU measure which captures intensity of pruritus and number of hives. Daily intensity of pruritus (range: 0 = none to 3 = severe) and number of hives ratings (range: 0 = none to 3 = more than 12 hives) are summed over a week to create theUAS7 (range: 0–42) score.

FEV1 (forced expiratory volume in 1 second): A measure of airway obstruction determined using spirometry. Individual FEV1 values are compared to predicted values based on age, height, sex and race. 'Estimated Comparative Daily Dosages for ICSs in Children' from the National Asthma Educational Prevention Program (NAEPP)-- EPR 3 Guidelines on Asthma by NAEPP. Figure 4–4b. Available at: https://www.nhlbi.nih.gov/sites/default/files/media/docs/asthgdln_1.pdf

**APPENDIX 6:**
First generation H1 antihistamine: hydroxyzine, cyproheptadine
Second generation H1 antihistamine: cetirizine, levocetirizine, fexofenadine, loratadine, desloratadine
Leukotriene receptor antagonist (LTRA): montelukast (Singulair), zafirlukast (Accolate), zileuton (Zyflo)
H2-Antihistamines: cimetidine (Tagamet), famotidine (Pepcid), nizatidine (Axid), ranitidine (Zantac)

## BACKGROUND AND OTHER CONSIDERATIONS

**BACKGROUND:**
NASAL POLYPS

The approval was supported by data from the phase 3 POLYP 1 (N=138) and POLYP 2 (N=127) trials evaluating the efficacy and safety of Xolair in adults with nasal polyps who had an inadequate response to nasal corticosteroids. Patients were randomized to receive either Xolair or placebo by subcutaneous injection every 2 to 4 weeks. The co-primary end points for both trials were change from baseline in Nasal Polyp Score (NPS) at week 24 and change from baseline in average daily Nasal Congestion Score (NCS) to week 24.

Results from both trials showed that patients treated with Xolair had a statistically significant greater improvement from baseline at week 24 in NPS and NCS compared with placebo, with improvements observed as early as week 4. Moreover, Xolair demonstrated statistically significant improvements on sense of smell score, post-nasal drip, and runny nose in both trials. The most common adverse reactions reported included headache, injection site reaction, arthralgia, upper abdominal pain and dizziness

ASTHMA

The National Heart, Lung and Blood Institute's Expert Panel Report 3 (EPR3) Guidelines for the Diagnosis and Management of Asthma recommend Xolair may be considered as adjunct therapy for patients 12 years and older with allergies and Step 5 or 6 (severe) asthma whose symptoms have not been controlled by ICS and LABA.

The Global Initiative for Asthma (GINA, 2022) recommends that patients 6 years and older may be treated with omalizumab as follows (Evidence A: Randomized controlled trials and meta-analyses. Rich body of evidence):

Suggested add-on treatment for patients ≥ 6 years with moderate or severe allergic asthma that is:

• uncontrolled on Step 4-5 treatment (Evidence A)

• Patients with severe asthma, uncontrolled on Step 4 treatment, may benefit from phenotyping into categories such as severe allergic, aspirin-exacerbated, or eosinophilic asthma. Patients ≥6 years with severe allergic asthma with elevated IgE levels may benefit from omalizumab (anti-IgE) therapy (Evidence A).

• Those with child-onset asthma and clinical history suggesting allergen-driven symptoms may predict a good asthma response to omalizumab therapy.

• Suggested initial trial of add-on anti-IgE for severe allergic asthma is at least 4 months. At that point, response to initial trial of add-on therapy should be reviewed. There are no well-defined criteria for good response, but exacerbations, symptom control, lung function, side effects, treatment intensity, and patient satisfaction should be considered. If the response is unclear, consider extending the trial to 6-12 months. If there is no response, stop the biologic therapy and consider switching to a different targeted therapy, if available

Global Initiative for Asthma (GINA, 2024)

Add-on biologic therapy: options recommended by GINA for patients with uncontrolled severe asthma despite optimized maximal therapy include:

- Add-on anti-immunoglobulin E treatment (omalizumab [Xolair]) for patients age ≥ 6 years with **severe allergic asthma** (Evidence A)
- Add-on anti-interleukin- 5/5R treatment (SC mepolizumab [Nucala] for patients age ≥ 6 years; IV reslizumab [Cinqair] for ages ≥18 years or SC benralizumab [Fasenra] for ages ≥12 years), with **severe eosinophilic asthma** (Evidence A)
- Add-on anti-interleukin-4Rα treatment (SC dupilumab [Dupixent]) for patients aged ≥ 6 years with **severe eosinophilic/type 2 asthma** or for **patients requiring treatment with maintenance OCS** (Evidence A)
- Add-On anti-thymic stromal lymphopoietin (anti TSLP) treatment (subcutaneous tezepelumab [Tezspire]) for patients aged ≥12 years with **severe asthma** (Evidence A)
- Suggested initial trial of add-on anti-IL5 for severe eosinophilic asthma is at least 4 months. At that point, response to initial trial of add-on therapy should be reviewed. There are no well- defined criteria for good response, but exacerbations, symptom control, lung function, side effects, treatment intensity, and patient satisfaction should be considered. If the response is unclear, consider extending the trial to 6-12 months. If there is no response, stop the biologic therapy and consider switching to a different targeted therapy, if available.

No significant changes in 2025.

CHRONIC URTICARIA

In 2014, the Joint Task Force on Practice Parameters (JTFPP), representing the American Academy of Allergy, Asthma & Immunology (AAAAI); the American College of Allergy, Asthma & Immunology (ACAAI); and the Joint Council of Allergy, Asthma & Immunology updated the practice parameter for the diagnosis and management of acute and chronic urticaria (CU). The practice parameter established a step-care approach to the treatment of chronic urticaria and angioedema. The task force recommended the following step-care treatment approach:

- Monotherapy with second-generation antihistamines: H1-antagonists are effective in the majority of patients with CU but might not achieve complete control in all patients.
- Dose advancement of H1-antihistamine therapy, combining first- and second-generation agents and adding an H2-antihistamine and/or an antileukotriene agent: Higher doses of second-generation antihistamines can provide greater efficacy when control is not achieved with conventional doses of these agents.
- Therapeutic trial of potent antihistamine (e.g., hydroxyzine or doxepin): First-generation antihistamines should be prescribed cautiously in the elderly or patients with occupations (e.g., machine operators, airline pilots, or alpine skiers) for which alertness is essential.
- Add an immunosuppressant or biologic agent: Omalizumab and cyclosporine have the greatest published experience documenting efficacy in patients with CU compared with all other alternative agents. The EAACI/GA2LEN/EDF/AAAAI/WAO Guideline for the Management of Urticaria include Xolair in combination with H1-antihistamines as a third line treatment option in patients who have failed to respond to higher doses of H1-Antihistamines.

The Joint Task Force on Practice Parameters representing various American allergy organizations include Xolair in combination with H1-antihistamines as a fourth line treatment option following a stepwise approach starting with a second-generation antihistamine. This is followed by one or more of the following: a dose increases of the second-generation antihistamine, or the addition of another second- generation antihistamine, H2-antagonist, LTRA, or first-generation antihistamine. Treatment with hydroxyzine or doxepin can be considered in patients whose symptoms remain poorly controlled.

FOOD ALLERGIES

The safety and efficacy of Xolair was evaluated in a multi-center, randomized, double-blind, placebo-controlled Food Allergy (FA) trial [NCT03881696] in 168 adult patients and pediatric patients 1 year of age to less than 56 years who were allergic to peanut and at least two other foods, including milk, egg, wheat, cashew, hazelnut, or walnut (i.e., studied foods). The FA trial enrolled patients who experienced dose-limiting symptoms (e.g., moderate to severe skin, respiratory or gastrointestinal symptoms) to a single dose of ≤100 mg of peanut protein and ≤300 mg protein for each of the other two foods (milk, egg, wheat, cashew, hazelnut, or walnut) during the screening double-blind placebo-controlled food challenge (DBPCFC). *Patients with a history of severe anaphylaxis (defined as neurological compromise or requiring intubation) were excluded from the study.* Patients were randomized 2:1 to receive a subcutaneous dosage of Xolair or placebo based on serum total IgE level (IU/mL), measured before the start of treatment, and by body weight for 16 to 20 weeks. After 16 to 20 weeks of treatment, each patient completed a DBPCFC consisting of placebo and each of their 3 studied foods. Following the DBPCFC, the first 60 patients that included 59 pediatric patients and one adult patient who completed the double-blind, placebo-controlled phase of the study could continue to receive Xolair in a 24 to 28 week open-label extension.

Efficacy of Xolair is based on 165 pediatric patients who were included in the efficacy analyses provided below. The mean age of the pediatric patients was 8 years (age range: 1 to 17 years).

The primary efficacy endpoint was the percentage of patients who were able to consume a single dose of ≥600 mg of peanut protein without dose-limiting symptoms (e.g., moderate to severe skin, respiratory or gastrointestinal symptoms) during DBPCFC. Xolair treatment led to a statistically higher response rate (68%) than placebo (5%). The secondary efficacy endpoints were the percentage of patients who were able to consume a single dose of ≥1000 mg of cashew, milk, or egg protein without dose-limiting symptoms during DBPCFC. The study met the secondary endpoints and demonstrated that Xolair treatment led to statistically higher response rates than placebo for all three foods.

Seventeen percent of Xolair treated patients were not able to consume >100 mg of peanut protein without moderate to severe dose-limiting symptoms. Eighteen, 22, and 41 percent of Xolair-treated patients were not able to consume >300 mg of milk, egg, or cashew protein, respectively, without moderate to severe dose-limiting symptoms.

Additional secondary analyses included the percentage of patients who were able to consume at least two or all three foods during DBPCFC. For two foods, 71% of Xolair treated patients were able to consume a single dose of ≥600 mg versus 5% in the placebo group and 67% were able to consume a single dose of ≥1000 mg versus 4% in the placebo group. For a single dose of ≥600 mg of three foods, the response rates were 48% in the Xolair group versus 4% in the placebo group and for a single dose of ≥1000 mg of three foods, the response rate in the Xolair group was 39% while none of the placebo patients were able to consume the challenge dose without symptoms.
The effectiveness of Xolair in adults is supported by the adequate and well-controlled trial of Xolair in pediatric patients, disease similarity in pediatric and adult patients, and pharmacokinetic (PK) similarity. While efficacy cannot be established from uncontrolled, open-label studies, for 38 pediatric patients who continued Xolair for 24-28 weeks in an open-label extension, the percentage of patients who were able to consume ≥600 mg of peanut protein and ≥1000 mg of egg, milk, and/or cashew protein without moderate to severe dose-limiting symptoms was maintained.

**CONTRAINDICATIONS/EXCLUSIONS/DISCONTINUATION:**
All other uses of Xolair (omalizumab) are considered experimental/investigational and therefore, will follow Molina's Off- Label policy. Contraindications to Xolair (omalizumab) include: Severe hypersensitivity reaction to omalizumab or any component of the formulation.

**Exclusions/Discontinuation**:
If the member is a smoker, the member has been counseled regarding the benefits of smoking cessation and/or connected with a program to support smoking cessation.
Underlying conditions or triggers for asthma or pulmonary disease must be maximally managed.
Possible conditions or triggers for urticaria must be maximally managed.
Do not use concurrently with any of the following: Anti-interleukin 4 therapy [e.g., Dupixent (dupilumab)], OR Anti- interleukin 5 therapy [e.g., Nucala (mepolizumab), Cinqair (reslizumab), Fasenra (benralizumab)], OR Anti-TSLP Tezspire (tezepelumab-ekko).

**OTHER SPECIAL CONSIDERATIONS:**
Xolair (omalizumab) has a Black Boxed warning for Anaphylaxis, presenting as bronchospasm, hypotension, syncope, urticaria, and/or angioedema of the throat or tongue, has been reported to occur after administration of omalizumab. Anaphylaxis has been reported after the first dose of Xolair but also beyond one year after beginning treatment. Individuals should be closely observed after Xolair administration as well as informed of signs and symptoms of anaphylaxis and to seek care immediately should symptoms occur.

## CODING/BILLING INFORMATION

***CODING DISCLAIMER.*** *Codes listed in this policy are for reference purposes only and may not be all-inclusive or applicable for every state or line of business. Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement. Listing of a service or device code in this policy does not guarantee coverage. Coverage is determined by the benefit document. Molina adheres to Current Procedural Terminology (CPT®), a registered trademark of the American Medical Association (AMA). All CPT codes and descriptions are copyrighted by the AMA; this information is included for informational purposes only. Providers and facilities are expected to utilize industry-standard coding practices for all submissions. Molina has the right to reject/deny the claim and recover claim payment(s) if it is determined it is not billed appropriately or not a covered benefit. Molina reserves the right to revise this policy as needed.*

| HCPCS CODE | DESCRIPTION |
|---|---|
| J2357 | Injection, omalizumab, 5 mg |

**AVAILABLE DOSAGE FORMS:**

Xolair SOLR 150MG single-dose vial
Xolair SOAJ 75MG/0.5ML single-dose prefilled autoinjector
Xolair SOAJ 150MG/ML single-dose prefilled autoinjector
Xolair SOAJ 300MG/2ML single-dose prefilled autoinjector
Xolair SOSY 75MG/0.5ML single-dose prefilled prefilled syringe
Xolair SOSY 150MG/ML single-dose prefilled prefilled syringe
Xolair SOSY 300MG/2ML single-dose prefilled prefilled syringe

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| SUMMARY OF REVIEW/REVISIONS | DATE |
|---|---|
| REVISION- Notable revisions:<br>Required Medical Information<br>Continuation of Therapy<br>Contraindications/Exclusions/Discontinuation<br>References | Q4 2025 |
| REVISION- Notable revisions:<br>Coding/Billing Information Template Update<br>Required Medical Information<br>Continuation of Therapy<br>Appendix<br>Available Dosage Forms<br>References | Q4 2024 |
| REVISION- Notable revisions:<br>Required Medical Information<br>Continuation of Therapy<br>Age Restrictions<br>Quantity<br>FDA-Approved Uses<br>Background<br>References | Q2 2024 |
| REVISION- Notable revisions:<br>Required Medical Information<br>Continuation of Therapy<br>Prescriber Requirements<br>Drug Class<br>FDA-Approved Uses<br>Appendix<br>Background<br>Contraindications/Exclusions/Discontinuation<br>References | Q4 2023 |

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|---|---|
| REVISION- Notable revisions:<br>Required Medical Information<br>References | Q1 2023 |
| REVISION- Notable revisions:<br>Required Medical Information<br>Continuation of Therapy<br>Prescriber Requirements<br>Age Restrictions<br>Quantity<br>FDA-Approved Uses<br>Appendix<br>Background<br>Contraindications/Exclusions/Discontinuation<br>References | Q4 2022 |
| Q2 2022 Established tracking in new format | Historical changes on file |