Cinqair (reslizumab) injection, for intravenous use

Policy Number: MC/PC 007
Effective Date: June 1, 2026

Instructions for Use

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Related Policies

- N/A

Coverage Rationale

This policy is applicable to Cinqair (reslizumab) injection for intravenous infusion only.

Severe Eosinophilic Asthma

For initial coverage of Cinqair (reslizumab) injection for severe eosinophilic asthma, the following will be required:

- Diagnosis of severe asthma **and**
- Asthma is an eosinophilic phenotype as defined by a baseline (pre-treatment) peripheral blood eosinophil level greater than or equal to 150 cells per microliter **and**
- One of the following:
  - Patient has had at least two or more asthma exacerbations requiring systemic corticosteroids (e.g., prednisone) within the past 12 months **or**
  - Prior asthma-related hospitalization within the past 12 months **and**
- Patient is 18 years of age or older **and**
- Patient is currently being treated with one of the following unless there is a contraindication or intolerance to these medications:
  - Both of the following:
    - High-dose inhaled corticosteroid (ICS) [e.g., greater than 500 mcg fluticasone propionate equivalent/day]
    - Additional asthma controller medication (e.g., leukotriene receptor antagonist [LTRA] [e.g., montelukast], long-acting beta-2 agonist [LABA] [e.g., salmeterol], long-acting muscarinic antagonist [LAMA] [e.g., tiotropium]) **or**
  - One maximally-dosed combination ICS/LABA product (e.g., Advair [fluticasone propionate 500 mcg/salmeterol 50 mcg], Symbicort [budesonide 160 mcg/formoterol 4.5 mcg], Breo Ellipta [fluticasone 200 mcg/vilanterol 25 mcg]) **and**
- Prescribed by or in consultation with one of the following:
  - Pulmonologist
  - Allergist/Immunologist

For reauthorization coverage of Cinqair (reslizumab) injection for severe eosinophilic asthma, the following will be required:

- Patient demonstrates 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**
- Patient continues to be treated with an inhaled corticosteroid (ICS) (e.g., fluticasone, budesonide) with or without additional asthma controller medication (e.g., leukotriene receptor antagonist [LTRA] [e.g., montelukast], long-acting beta-2 agonist [LABA] [e.g., salmeterol], long-acting muscarinic antagonist [LAMA] [e.g., tiotropium]) unless there is a contraindication or intolerance to these medications **and**
- Prescribed by or in consultation with one of the following:
    - Pulmonologist
    - Allergist/Immunologist

Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

HCPCS Code	Description
J2786	Injection, reslizumab, 1mg

ICD-10 Code	Description
J45.50	Severe persistent asthma, uncomplicated
J45.51	Severe persistent asthma with (acute) exacerbation
J45.52	Severe persistent asthma with status asthmaticus
J82.81	Eosinophilic pneumonia, NOS
J82.82	Acute eosinophilic pneumonia
J82.83	Eosinophilic asthma
J82.89	Other pulmonary eosinophilia, not elsewhere classified

Background

Respiratory and allergy biologics are a mainstay of treatment for severe asthma. Asthma is a chronic lung disease that inflames and narrows the airways, making it difficult to breathe. Asthma causes recurring periods of wheezing, chest tightness, shortness of breath, and coughing. In 2022, asthma affected an estimated 22 million adults and 4.5 million children in the United States (U.S.) (Centers for Disease Control and Prevention Web site 2023). Current pharmacologic options for asthma management are categorized as: (1) controller medications to achieve and maintain control of persistent asthma or prevent exacerbations, and (2) reliever medications for symptom relief and before exercise to prevent exercise-induced asthma symptoms (Cloutier et al 2020, NHLBI 2007, Global Initiative for Asthma [GINA] 2025). Severe asthma is defined as asthma that remains uncontrolled despite optimized treatment with high-dose ICS/LABA treatment and management of contributory factors, or that worsens when high-dose treatment is decreased (GINA 2025).

Cinqair (reslizumab) is an interleukin-5 (IL-5) antagonist monoclonal antibody (IgG4 kappa) indicated for add-on maintenance treatment of patients with severe asthma aged 18 years and older, and with an eosinophilic phenotype. IL-5 is the major cytokine responsible for the growth and differentiation, recruitment, activation, and survival of eosinophils. Reslizumab binds to IL-5 with a dissociation constant of 81 pM, inhibiting the bioactivity of IL-5 by blocking its binding to the alpha chain of the IL-5 receptor complex expressed on the eosinophil surface. Inflammation is an important component in the pathogenesis of asthma. Multiple cell types (e.g., mast cells, eosinophils, neutrophils, macrophages, lymphocytes) and mediators (e.g., histamine, eicosanoids, leukotrienes, cytokines) are involved in inflammation. Reslizumab, by inhibiting IL-5 signaling, reduces the production and survival of eosinophils; however, the mechanism of reslizumab action in asthma has not been definitively established.

Clinical Evidence

Asthma

The safety and efficacy of reslizumab were evaluated in 4 double-blind, placebo-controlled, multicenter, RCTs. In all 4 studies, patients were required to be on at least a medium-dose ICS with or without additional controller medications (Bjermer et al 2016, Castro et al 2015, Corren et al 2016).

- Studies 3082 and 3083 were 52-week studies (N = 953) in patients with asthma who were required to have a blood eosinophil count ≥ 400 cells/µL, and ≥ 1 asthma exacerbation requiring systemic corticosteroid use over the past 12 months. These studies compared the asthma exacerbation rate and improvements in clinical symptoms between patients receiving reslizumab 3 mg/kg IV administered once every 4 weeks and placebo. Reslizumab also had a significant reduction in the frequency of asthma exacerbations with those receiving placebo (Castro et al 2015).
- Study 3081 was a 16-week study (N = 315) in patients who were required to have a blood eosinophil count ≥ 400 cells/µL. The study compared the change from baseline in FEV1 and improvements in clinical symptoms between reslizumab 3 mg/kg vs placebo. Reslizumab 3 mg/kg significantly improved FEV1 (difference vs placebo: 160 mL; 95% CI, 60 to 259; p = 0.0018). Reslizumab also statistically significantly improved Asthma Control Questionnaire (ACQ) and Asthma Quality of Life Questionnaire (AQLQ); however, the minimally important difference was only reached for AQLQ (Bjermer et al 2016).
- Study 3084 was a 16-week study in 496 patients unselected for baseline blood eosinophil levels (approximately 80% of patients had a screening blood eosinophil count < 400 cells/µL). Patients were not allowed to be on maintenance OCS. The study compared the change from baseline in FEV1 and improvements in clinical symptoms between reslizumab 3 mg/kg vs placebo. In the subgroup of patients with baseline eosinophils < 400 cells/µL, patients treated with reslizumab showed no significant improvement in FEV1 compared with placebo. In the subgroup with eosinophils ≥ 400 cells/µL, however, treatment with reslizumab was associated with much larger improvements in FEV1, ACQ, and rescue SABA use compared with placebo (Corren et al 2016).
- A 2017 meta-analysis of 5 RCTs comparing reslizumab to placebo (N = 1366) revealed improvements in exacerbations, FEV1, and ACQ score with reslizumab. Asthma exacerbations occurred less frequently in reslizumab-treated patients vs placebo (OR, 0.46; 95% CI, 0.35 to 0.59; p < 0.00001). FEV1 also improved with reslizumab compared to placebo (mean difference, 0.16; 95% CI, 0.10 to 0.23; p < 0.00001). Finally, Asthma Control Questionnaire (ACQ) score improved with reslizumab compared to placebo (mean difference, -0.26; 95% CI, -0.36 to -0.16; p < 0.00001). All studies included in the meta-analysis were of limited duration of 15 or 16 weeks (Li et al 2017).
- A 2019 meta-analysis of 6 RCTs (5 placebo-controlled trials and 1 open-label extension) evaluated the safety of reslizumab (n = 1028) with placebo (n = 730) in adults with uncontrolled asthma. Compared with placebo, reslizumab was associated with lower proportions of patients with ≥ 1 adverse event (67% vs 81%; RR, 0.83; 95% CI, 0.79 to 0.89) and with ≥ 1 serious adverse event (7% vs 10%; RR, 0.65; 95% CI, 0.48 to 0.89) (Virchow et al 2020).

Clinical Guidelines

The National Asthma Education and Prevention Program (NAEPP) guideline from the NHLBI states that the initial treatment of asthma should correspond to the appropriate asthma severity category, and it provides a stepwise

approach to asthma management. Long-term control medications such as ICSs, long-acting bronchodilators, leukotriene modifiers, cromolyn, and immunomodulators should be taken daily on a long-term basis to achieve and maintain control of persistent asthma. ICSs are the most potent and consistently effective long-term asthma control medication. Quick-relief medications such as SABAs and anticholinergics are used to provide prompt relief of bronchoconstriction and accompanying acute symptoms such as cough, chest tightness, and wheezing. Systemic corticosteroids are important in the treatment of moderate or severe exacerbations because these medications prevent progression of the exacerbation, speed recovery, and prevent relapses (NHLBI 2007). A 2020 focused update of the 2007 NAEPP guideline has provided additional updated recommendations on the use of intermittent ICSs and the use of LAMAs as add-on therapy (Cloutier et al 2020).

The 2025 GINA report also provides a stepwise approach to asthma management (GINA 2025). Treatment recommendations are based on patient age, and stepping down should be considered when asthma symptoms have been well-controlled and lung function has been stable for ≥ 2 to 3 months. ICS/beta-2 agonist combination products are recommended for both controller (i.e., maintenance treatment) and reliever use in patients ≥ 6 years of age, while the preferred controller option in patients ≤ 5 years of age consists of low-dose ICS for Step 2 and double low-dose ICS for Step 3, with a specialist assessment recommended for Step 4 if a patient's asthma is not well-controlled on double low-dose ICS. In patients ≥ 6 years of age diagnosed with severe asthma and uncontrolled on Step 4 treatment, phenotyping for Type 2 inflammation into categories such as severe allergic, aspirin-exacerbated, allergic bronchopulmonary aspergillosis, chronic rhinosinusitis, nasal polyposis, atopic dermatitis, or eosinophilic asthma is recommended. Add-on treatment with a biologic agent should be considered as follows:

- Severe allergic asthma: Anti-IgE treatment with omalizumab is recommended for patients ≥ 6 years of age.
- Severe eosinophilic asthma: Add-on anti-IL-5 therapy is recommended for patients ≥ 6 years of age (mepolizumab and benralizumab), or ≥ 18 years of age (reslizumab).
- Severe eosinophilic/Type 2 asthma: Anti-IL4 therapy (dupilumab) is recommended for patients ≥ 6 years of age.
- Adults or adolescents requiring oral corticosteroids for maintenance therapy: Anti-IL4 therapy (dupilumab) is recommended.
- Severe asthma: Anti-TSLP therapy (tezepelumab-ekko) is recommended for patients ≥ 12 years of age.
- Prior to initiation of a biologic agent, several factors should be considered including cost, insurance eligibility criteria, evaluation of predictors of response, delivery route, dosing frequency, and patient preference.

The European Respiratory Society/American Thoracic Society guideline on the management of severe asthma suggests the use of anti-IL-5 therapy as an add-on in adults with severe uncontrolled eosinophilic asthma or severe corticosteroid-dependent asthma. A blood eosinophil count of ≥ 150 cells/µL is suggested as a cut-point to guide initiation of anti-IL-5 therapy in adults with severe asthma and prior exacerbations. A blood eosinophil count of ≥ 260 cells/µL or an exhaled nitric oxide level of 19.5 parts per billion or greater may be used to identify adolescents and adults with severe allergic asthma who are likely to benefit from anti-IgE treatment (Holguin et al 2020).

The American College of Chest Physicians (ACCP) also developed a guideline addressing biologic management in adults with severe asthma. For adults with moderate to severe allergic asthma and ≥ 1 exacerbation per year requiring OCS, the panel recommends treatment with either omalizumab or dupilumab, using individual clinical characteristics to guide selection. For severe, steroid-dependent asthma, the panel recommends either anti-IL-5/IL-5 receptor alpha (IL-5 R α) therapy or dupilumab and recommends dupilumab over tezepelumab-ekko. For moderate to severe asthma that does not demonstrate a clinical response to omalizumab after 4 to 6 months, the panel recommends switching to either anti-IL-5/IL-5R α therapy or dupilumab. For severe asthma that does not respond to anti-IL-5/IL-5R α therapy after 4 to 6 months, the panel recommends either dupilumab or tezepelumab-ekko, with dupilumab preferred in those who are steroid dependent. For those who do not respond to dupilumab after 4 to 6 months, the panel recommends either anti-IL-5/IL-5R α therapy or tezepelumab-ekko, with anti-IL-5/IL-5R α therapy preferred in steroid-dependent patients. Finally, for those with severe asthma receiving anti-IL-5/IL-5R α therapy who have not demonstrated a clinical response by 4 to 6 months, the panel recommends using a post-treatment FeNO ≥25 ppb to guide switching to dupilumab. All

recommendations carry a conditional strength of recommendation and are based primarily on very low-certainty evidence (Oberle et al 2026).

U.S. Food and Drug Administration (FDA)

This section is to be used for informational purposes only. FDA approval alone is not a basis for coverage.

Cinqair is an interleukin-5 antagonist monoclonal antibody (IgG4 kappa) indicated for add-on maintenance treatment of patients with severe asthma aged 18 years and older, and with an eosinophilic phenotype.

References

1. Bjermer L, Lemiere C, Maspero J, Weiss S, Zangrilli J, Germinaro M. Reslizumab for inadequately controlled asthma with elevated blood eosinophil levels: a randomized phase 3 study. *Chest*. 2016;150(4):789-798.
2. Cinqair [package insert], information. Frazer, PA: Teva Pharmaceutical Industries Ltd.; November 2025.
3. Castro M, Zangrilli J, Wechsler ME, et al. Reslizumab for inadequately controlled asthma with elevated blood eosinophil counts: results from two multicentre, parallel, double-blind, randomised, placebo-controlled, phase 3 trials. *Lancet Respir Med*. 2015;3(5):355-366.
4. Centers for Disease Control and Prevention (CDC). Most recent national asthma data. 2022. Updated May 10, 2023. CDC Web site. https://www.cdc.gov/asthma-data/about/most-recent-asthma-data.html. Accessed April 1, 2026.
5. Cloutier MM, Dixon AE, Krishnan JA, et al. Managing asthma in adolescents and adults: 2020 asthma guideline update from the National Asthma Education and Prevention Program. *JAMA*. 2020;324(22):2301-2317. doi: 10.1001/jama.2020.21974.
6. Corren J, Weinstein S, Janka L, Zangrilli J, Garin M. Phase 3 study of reslizumab in patients with poorly controlled asthma: effects across a broad range of eosinophil counts. *Chest*. 2016;150(4):799-810.
7. Global Initiative for Asthma (GINA). Global strategy for asthma management and prevention. 2025. http://www.ginasthma.org. Accessed April 1, 2026.
8. Holguin F, Cardet JC, Chung KF, et al. Management of severe asthma: a European Respiratory Society/American Thoracic Society guideline. *Eur Respir J*. 2020;55(1). pii: 1900588. doi: 10.1183/13993003.00588-2019.
9. Li J, Wang F, Lin C, et al. The efficacy and safety of reslizumab for inadequately controlled asthma with elevated blood eosinophil counts: a systematic review and meta-analysis. *J Asthma*. 2017;54(3):300-307.
10. National Heart, Lung, and Blood Institute. Expert Panel Report 3: Guidelines for the diagnosis and management of asthma (guideline on the Internet). 2007. https://www.ncbi.nlm.nih.gov/books/NBK7232/. Accessed April 1, 2026.
11. Oberle AJ, Abbas F, Adrish M, et al. Biologic management in severe asthma for adults: An American College of Chest Physicians Clinical Practice Guideline. *Chest*. 2026;169(2):336-348. doi:10.1016/j.chest.2025.08.042
12. Virchow JC, Katial R, Brusselle GG, et al. Safety of reslizumab in uncontrolled asthma with eosinophilia: a pooled analysis from 6 trials. *J Allergy Clin Immunol Pract*. 2020;8(2):540-548. doi: 10.1016/j.jaip.2019.07.038.

Policy History/Revision Information

Date	Summary of Changes
11/16/2023	Approved by OptumRx P&T Committee
05/16/2024	Annual Review. Updated criteria language in coverage rationale section in line with other drugs in same class. Updated references.
05/15/2025	Annual Review. Updated Background and Clinical Guidelines sections. Updated references.

Date	Summary of Changes
05/14/2026	Annual Review. Update to age criterion to reflect standard verbiage. Updated clinical guidelines and references.

Instructions for Use

This Medical Benefit Drug Policy provides assistance in interpreting standard benefit plans. When deciding coverage, the member specific benefit plan document must be referenced as the terms of the member specific benefit plan may differ from the standard plan. In the event of a conflict, the member specific benefit plan document governs. Before using this policy, please check the member specific benefit plan document and any applicable federal or state mandates. The insurance reserves the right to modify its Policies and Guidelines as necessary. This Medical Benefit Drug Policy is provided for informational purposes. It does not constitute medical advice.

OptumRx may also use tools developed by third parties to assist us in administering health benefits. OptumRx Medical Benefit Drug Policies are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.

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Discrimination is Against the Law. Aspirus Health Plan, Inc. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, (including sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation, gender identity and sex stereotypes), consistent with the scope of sex discrimination described at 45 CFR § 92.101(a)(2). Aspirus Health Plan, Inc. does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

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- Qualified sign language interpreters.
- Written information in other formats (large print, audio, accessible electronic formats, other formats).

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- Qualified interpreters.
- Information written in other languages.

If *you* need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact the Nondiscrimination Grievance Coordinator at the address, phone number, fax number, or email address below.

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Aspirus Health Plan, Inc.
PO Box 1890
Southampton, PA 18966-9998
Phone: 1-866-631-5404 (TTY: 711)
Fax: 763-847-4010
Email: customerservice@aspirushealthplan.com

You can file a *grievance* in person or by mail, fax, or email. If *you* need help filing a *grievance*, the Nondiscrimination Grievance Coordinator is available to help *you*.

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200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
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Albanian: KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë.Telefononi në 1-800-332-6501 (TTY: 711).

Arabic تنبيه: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية متاحة لك مجاناً. اتصل بن اعلى رقم الهاتف1-800-332-6501(رقم هاتف الصم والبك : 711)

French: ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-332-6501 (ATS: 711).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zurVerfügung. Rufnummer: 1-800-332-6501 (TTY: 711).

Hindi: _यान द_: य_द आप ि हंदी बोलते ह_ तो आपके ि लए मु_त म_ भाषा सहायता सेवाएं उपल_ध ह_।1-800-332-6501 (TTY: 711) पर कॉल कर_।

Hmong: LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800-332-6501 (TTY: 711).

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.1-800-332-6501 (TTY: 711)번으로 전화해 주십시오.

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Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-332-6501 (TTY: 711).

Pennsylvania Dutch: Wann du Deitsch (Pennsylvania German / Dutch) schwetzscht, kannscht du mitaus Koschte ebbergricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-800-332-6501 (TTY: 711).

Lao: ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ,ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-800-332-6501 (TTY: 711).

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