

Reslizumab (CINQAIR) Criteria for Use

VA Pharmacy Benefits Management Services, Medical Advisory Panel, and VISN Pharmacist Executives

The following recommendations are based on medical evidence, clinician input, and expert opinion. The content of the document is dynamic and will be revised as new information becomes available. The purpose of this document is to assist practitioners in clinical decision-making, to standardize and improve the quality of patient care, and to promote cost-effective drug prescribing. **THE CLINICIAN SHOULD UTILIZE THIS GUIDANCE AND INTERPRET IT IN THE CLINICAL CONTEXT OF THE INDIVIDUAL PATIENT. INDIVIDUAL CASES THAT ARE EXCEPTIONS TO THE EXCLUSION AND INCLUSION CRITERIA SHOULD BE ADJUDICATED AT THE LOCAL FACILITY ACCORDING TO THE POLICY AND PROCEDURES OF ITS P&T COMMITTEE AND PHARMACY SERVICES.**

Exclusion Criteria (if ONE is checked, patient is not eligible)

- Prior allergic reaction to reslizumab
- Acute exacerbation of asthma or status asthmaticus
- Currently treated with omalizumab or mepolizumab (unless they are to be discontinued when reslizumab initiated)
- Currently undergoing bronchial thermoplasty

Inclusion Criteria

- Provider is an asthma specialist (pulmonologist, allergist, immunologist)
- Diagnosis of asthma
- Receiving at least medium-dose inhaled corticosteroid AND ≥ 3 months of a second controller drug (i.e. long-acting beta agonist, long-acting muscarinic antagonist, leukotriene receptor antagonist) \pm oral corticosteroid*
- Blood eosinophil ≥ 400 cells/ μ L or sputum eosinophils $\geq 3\%$ obtained within 4 weeks of dosing
- Adherent to asthma medications as evidenced by a review of prescription refill history during the last 12 months
- Patient should be nonsmoking and if not, actively receiving smoking cessation treatment**

AND at least ONE of the following:

- ≥ 2 exacerbations requiring systemic corticosteroid OR ≥ 1 hospitalization due to asthma exacerbation in the prior year
- Requires maintenance oral steroids
- Inadequate symptom control (e.g., short-acting beta-agonist use > 2 days/week, nighttime awakening due to asthma > 1 time/week, limitation with normal activity, Asthma Control Test < 19 , or Asthma Control Questionnaire > 1.5)

*Providers should observe patient's inhaler use, as poor technique frequently is a cause of poor results in asthma

**Patients who were currently smoking were excluded from clinical trials. Malignant neoplasm was reported in 0.6% of patients receiving reslizumab and 0.3% of patients in the placebo group. It is unknown if the risk of cancer is increased in those who smoke while using reslizumab. The decision to use reslizumab in patients who have had unsuccessful attempts at smoking cessation should be made on a case-by-case basis.

Dosage and Administration

Please refer to Product Information for detailed information on preparation, dosage, and administration

Note: Reslizumab is administered via intravenous infusion. Reslizumab should be administered in a healthcare setting by a healthcare professional prepared to manage anaphylaxis.

Issues for Consideration

Anaphylaxis: See boxed warning. Anaphylaxis occurred with reslizumab infusion in 0.3% of patients in placebo-controlled trials. Anaphylaxis events were observed during or within 20 minutes after completion of the reslizumab infusion and reported as early as the second dose of reslizumab. Manifestations included dyspnea, decreased oxygen saturation, wheezing, vomiting, and skin and mucosal involvement, including urticaria. In all 3 cases, reslizumab was discontinued.

Malignancy: in the placebo-controlled trials, 6/1028 (0.6%) patients receiving reslizumab had at least one malignant neoplasm reported compared to 2/730 (0.3%) patients in the placebo group. The malignancies reported in the reslizumab group were diverse in nature and without clustering of any particular tissue type. The majority were diagnosed within less than six months of exposure to reslizumab.

Reduction of corticosteroid dosage: no clinical studies have been conducted to assess reduction of maintenance corticosteroid dosages following administration of reslizumab. Do not abruptly discontinue systemic or inhaled steroids upon initiation of reslizumab. If appropriate, reduction should be done gradually and under the care of a physician.

Parasitic (helminth) infection: It is unknown if reslizumab will influence a patient's response against parasitic infections (patients with known parasitic infections were excluded from the clinical trials). Pre-existing infection should be treated prior

to initiating therapy with reslizumab. If an infection occurs while being treated with reslizumab and does not respond to anti-helminth therapy, discontinue reslizumab until infection resolves.

Elevations in CPK/myalgia: Transient elevation in CPK in those with normal baseline values occurred in 20% and 18% of the reslizumab and placebo groups respectively during routine laboratory assessment. CPK elevation >10x ULN regardless of baseline value were reslizumab (0.8%) and placebo (0.4%). Elevations >10 x ULN were asymptomatic and did not lead to treatment discontinuation. Myalgia was reported in 1% of the reslizumab 3mg/kg group compared to 0.5% of the placebo group. On the day of infusion, musculoskeletal AEs were reported in 2.2% of the reslizumab 3mg/kg and 1.5% of the placebo groups. These reactions included musculoskeletal chest pain, neck pain, muscle spasm, extremity pain, muscle fatigue and musculoskeletal pain.

The reslizumab studies included a majority of female patients (62%) and majority of white patients (73%). Genetics and hormonal differences play a large part in how patients respond to asthma therapy, and should be considered when starting reslizumab.

In the clinical trials, patients who had previously received omalizumab were eligible for inclusion into the study if they had not received omalizumab for at least 6 months. The washout period was to avoid any potential carry over from omalizumab which has a long half-life. There are no recommendations in the labeling requiring a waiting period before starting reslizumab; however, providers should be aware of any potential adverse drug events.

Monitoring

Effectiveness of therapy should be evaluated within 6 months. Goal should be the objective improvement in selected markers of asthma control, such as symptoms severity, frequency of rescue treatments, oral steroid requirements, and frequency of urgent outpatient visits and/or hospitalization. This information should be used to determine continuation of therapy.

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