

Applicable Drugs: Brinsupri (brensocatib)

Preferred: N/A

Non-preferred: N/A

Date of Origin: 2/9/2026

Date Last Reviewed / Revised: N/A

PRIOR AUTHORIZATION CRITERIA

(May be considered medically necessary when criteria I through V are met)

- I. Documented diagnosis of non-cystic fibrosis bronchiectasis (NCFB) and meets all the following criteria (A through D):
 - A. Chest computed tomography (CT) scan confirming bronchiectasis diagnosis.
 - B. Clinical presentation consistent with bronchiectasis (eg, chronic cough, chronic sputum production, and/or recurrent respiratory tract infections).
 - C. Provider-attested compliance with or contraindication to airway clearance techniques and/or pulmonary rehabilitation for at least 3 months.
 - D. Treatment failure or contraindication to clinically appropriate antibiotic therapy (see Table 1) for at least 3 months AND meets one of the following criteria (i or ii):
 - i. 18 years and older: At least two pulmonary exacerbations requiring antibiotic therapy within the past 12 months.
 - ii. 12-17 years old: At least one pulmonary exacerbation requiring antibiotic therapy within the past 12 months.
 - E. Current non-smoking status.
- II. Minimum age requirement: 12 years old.
- III. Treatment is prescribed by or in consultation with a pulmonologist.
- IV. Request is for a medication with the appropriate FDA labeling, or its use is supported by current clinical practice guidelines.
- V. Refer to the plan document for the list of preferred products. If the requested agent is not listed as a preferred product, must have a documented failure, intolerance, or contraindication to a preferred product(s).

EXCLUSION CRITERIA

- Diagnosis of cystic fibrosis.
- Respiratory symptoms are primarily driven by asthma or chronic obstructive pulmonary disease (COPD).

- Currently being treated for nontuberculous mycobacteria (NTM) lung infection, allergic bronchopulmonary aspergillosis, or tuberculosis (TB).

OTHER CRITERIA

- N/A

QUANTITY / DAYS SUPPLY RESTRICTIONS

- 30 tablets per 30 days

APPROVAL LENGTH

- **Authorization:** 6 months
- **Re-Authorization:** 12 months, with an updated letter of medical necessity or progress notes showing current medical necessity criteria are met and that the medication is effective (eg, reduction in respiratory symptoms, antibiotic use, urgent care or ER visits, or hospitalizations).

APPENDIX

- Guideline recommended antibiotics include oral macrolides (eg, azithromycin, erythromycin) and inhaled tobramycin and aztreonam.

Table 1. Guideline Recommended Antibiotic Treatment Duration Per Exacerbation History

Age	Short-term Treatment (14-21 days)	Long-term Treatment (3+ months)
18+ years	2 PEs per year	3+ PEs per year
12-17 years	1-2 non-hospitalized PEs per year	1 hospitalized PE per year OR 3+ non-hospitalized PEs per year

PE: pulmonary exacerbation

REFERENCES

1. Brinsupri. Prescribing information. Insmed Incorporated; 2025. Accessed January 5, 2026. <https://www.brinsupri.com/pdfs/full-prescribing-information.pdf>
2. Hill AT, Sullivan AL, Chalmers JD, et al. British Thoracic Society Guideline for bronchiectasis in adults. Thorax. 2018;74:1-69. doi:10.1136/thoraxjnl-2018-212463
3. Polverino E, Goeminne PC, McDonnell MJ, et al. European Respiratory Society guidelines for the management of adult bronchiectasis. European Respiratory Journal. 2017;50(3):1700629. doi:10.1183/13993003.00629-2017
4. Chang AB, Fortescue R, Grimwood K, et al. European Respiratory Society guidelines for the management of children and adolescents with bronchiectasis. European Respiratory Journal. 2021;58(2):2002990. doi:10.1183/13993003.02990-2020

DISCLAIMER: Medication Policies are developed to help ensure safe, effective and appropriate use of selected medications. They offer a guide to coverage and are not intended to dictate to providers how to practice medicine. Refer to Plan for individual adoption of specific Medication Policies. Providers are expected to exercise their medical judgement in providing the most appropriate care for their patients.