

Applicable Drugs: Cinqair (reslizumab)

Preferred: N/A

Non-preferred: N/A

Date of Origin: 8/26/2024

Date Last Reviewed / Revised: 5/6/2026

PRIOR AUTHORIZATION CRITERIA

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

- I. Documented diagnosis of severe asthma with an eosinophilic phenotype AND must meet the following criteria:
 - A. Documented blood eosinophilia count of at least 300 cells/mcL at baseline.
 - B. Documentation that the patient has been on a minimum of a six-month trial of a high-dose inhaled corticosteroid (ICS) used in combination with a long-acting inhaled beta-2 agonist (LABA).
 - C. Documentation that the patient's asthma symptoms are poorly controlled despite therapy AND meets at least one of the following criteria:
 - i. Poor symptom control (eg, Asthma Control Questionnaire [ACQ] score consistently greater than 1.5 or Asthma Control Test [ACT] score consistently less than 20).
 - ii. Two or more asthma exacerbations requiring systemic corticosteroids within the past 12 months.
 - iii. One or more asthma exacerbations requiring emergency treatment (ie, hospitalization, mechanical ventilation, emergency room visit) within the past 12 months.
 - iv. Worsening asthma when oral corticosteroids are tapered.
 - v. Baseline forced expiratory volume in one second (FEV1) less than 80% predicted.
 - D. Documentation that Cinqair will be used in conjunction with ICS + LABA therapy as an add-on maintenance treatment.
- II. Minimum age requirement: 18 years old.
- III. Treatment must be prescribed by or in consultation with an allergist, immunologist, or 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 documented treatment failure or contraindication to the preferred product(s).

EXCLUSION CRITERIA

- Treatment of other eosinophilic conditions.
- Treatment of acute bronchospasm or status asthmaticus.
- Concurrent use with other anti-asthma monoclonal antibodies (ie, Xolair [omalizumab], Dupixent [dupilumab], Exdensusur [depemokimab], Fasenra [benralizumab], Nucala [mepolizumab], Tezspire [tezepelumab]).

OTHER CRITERIA

- N/A

QUANTITY / DAYS SUPPLY RESTRICTIONS

- 3 mg/kg once every 4 weeks by intravenous infusion.
 - Available as 100 mg/10 mL vials.

APPROVAL LENGTH

- **Authorization:** 6 months.
- **Re-Authorization:** 12 months, with updated letter of medical necessity or progress notes showing that current medical necessity criteria are met and that the medication is effective.

APPENDIX

N/A

REFERENCES

1. Cinqair. Prescribing information. Teva; 2020. Accessed May 6, 2026. <https://www.cinqair.com/globalassets/cinqair/prescribinginformation.pdf>.
2. Global Initiative for Asthma. Global Strategy for Asthma Management and Prevention. 2026. Accessed May 6, 2026. <https://ginasthma.org/2026-gina-strategy-report/>

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.