Clinical Policy Title: Omalizumab for the treatment of chronic idiopathic urticaria

Clinical Policy Number: 18.02.07

Effective Date: April 1, 2016
Initial Review Date: January 20, 2016
Most Recent Review Date: November 16, 2017
Next Review Date: November 2018

Related policies:

CP# 07.03.01 Bronchial thermoplasty for severe asthma

ABOUT THIS POLICY: Select Health of South Carolina has developed clinical policies to assist with making coverage determinations. Select Health of South Carolina’s clinical policies are based on guidelines from established industry sources, such as the Centers for Medicare & Medicaid Services (CMS), state regulatory agencies, the American Medical Association (AMA), medical specialty professional societies, and peer-reviewed professional literature. These clinical policies along with other sources, such as plan benefits and state and federal laws and regulatory requirements, including any state- or plan-specific definition of “medically necessary,” and the specific facts of the particular situation are considered by Select Health of South Carolina when making coverage determinations. In the event of conflict between this clinical policy and plan benefits and/or state or federal laws and/or regulatory requirements, the plan benefits and/or state and federal laws and/or regulatory requirements shall control. Select Health of South Carolina’s clinical policies are for informational purposes only and not intended as medical advice or to direct treatment. Physicians and other health care providers are solely responsible for the treatment decisions for their patients. Select Health of South Carolina’s clinical policies are reflective of evidence-based medicine at the time of review. As medical science evolves, Select Health of South Carolina will update its clinical policies as necessary. Select Health of South Carolina’s clinical policies are not guarantees of payment.

Coverage policy


- Member has documented urticaria ≥3 months requiring oral steroid management AND
- Symptomatology is refractory to:
  - Two H-1 antihistamines (e.g., hydroxyzine, cyproheptadine, loratadine) AND
  - One H-2 antihistamine (e.g., ranitidine, famotidine) AND
  - Montelukast

Limitations:

The prescribing physician is an allergist, immunologist or dermatologist; or physician documentation is submitted indicating that omalizumab was recommended by a specialist physician that treats urticaria.
If all of the above conditions are met, the request will be approved for a four-month term; if all of the above criteria are not met, the request is referred to a Medical Director or clinical reviewer for medical necessity review.

See Appendix A for PerformRx\textsuperscript{SM} prior authorization criteria for omalizumab.

**Alternative covered services:**

- Routine patient evaluation and management by a network healthcare provider.

**Background**

Chronic idiopathic urticaria is defined as itchy hives of at least six weeks duration that have no apparent external trigger (Urgert 2015, Fonacier 2010). The cause of chronic urticaria is often difficult to pinpoint; however, known etiologies include autoimmune urticaria, physical urticarias (e.g., cold, cholinergic and delayed pressure urticaria), and idiopathic urticaria. Diagnosis requires a detailed patient history and comprehensive physical examination, with additional testing tailored to the patient’s history.

Non-sedating antihistamines are the current mainstay for initial treatment; however, many afflicted individuals do not achieve a therapeutic response to this therapy even when high doses are used.

Effective treatments include anti-histamines, leukotriene receptor antagonists in combination with anti-histamines, and oral immunomodulatory drugs, including corticosteroids, cyclosporine, dapsone, hydroxychloroquine, and sulfasalazine. Emerging therapies for the condition include intravenous immunoglobulin and omalizumab.

**Searches**

Select Health of South Carolina searched PubMed and the databases of:

- UK National Health Services Center for Reviews and Dissemination.
- Agency for Healthcare Research and Quality’s National Guideline Clearinghouse and other evidence-based practice centers.
- The Centers for Medicare & Medicaid Services (CMS).

We conducted searches on October 3, 2017. Search terms were: "omalizumab [MeSH]"; "chronic idiopathic urticaria [MeSH]."

We included:

- **Systematic reviews**, which pool results from multiple studies to achieve larger sample sizes and greater precision of effect estimation than in smaller primary studies. Systematic reviews use predetermined transparent methods to minimize bias, effectively treating the review as a scientific endeavor, and are thus rated highest in evidence-grading hierarchies.
• Guidelines based on systematic reviews.
• Economic analyses, such as cost-effectiveness, and benefit or utility studies (but not simple cost studies), reporting both costs and outcomes — sometimes referred to as efficiency studies — which also rank near the top of evidence hierarchies.

Findings

A systematic review (Maurer 2017) stated that omalizumab has substantial benefits in patients with chronic urticaria. Therapy induced a rapid onset of symptom control in most cases, often within 24 hours. Many patients gained complete/partial symptom relief and substantially improved quality of life. Adverse events were generally low, with omalizumab being well tolerated by most patients, including children.

A systematic review (Tonacci 2017) evaluated the efficacy of omalizumab for the treatment of chronic idiopathic urticaria. Omalizumab 300 mg administered every 4 weeks was the most effective and safe dosage, with a rapid response time and few minor adverse effects.

A systematic review (Chia 2016) noted that omalizumab is effective in a variety of recalcitrant immune-mediated and autoimmune skin disorders, and it is a safe and effective treatment for use in chronic idiopathic urticaria (Grade of recommendation: A).

Practice guidelines (Kulthanon 2016) for the diagnosis and management of urticaria note that routine laboratory investigation is not cost-effective in the initial workup of chronic urticaria. Non-sedating H1-antihistamine is first-line treatment for 2-4 weeks; if urticaria is not controlled, increasing the dose is recommended. Sedating first-generation antihistamines have not been proven more advantageous than non-sedating antihistamines. Holistic means to minimize hyper-responsive skin are also important (e.g., prevention of skin from drying, avoidance of hot showers, scrubbing, and avoidance of excessive sun exposure. Omalizumab has established efficacy but its high cost may preclude use in low to middle income demographic groups.

A systematic review and meta-analysis (Zhao 2016) evaluated the efficacy and safety of different doses of omalizumab for the treatment of chronic urticaria. Patients treated with omalizumab 75 to 600 mg every four weeks had significantly reduced weekly itch scorers compared with treatment by placebo. Omalizumab's effects were dose dependent, with the strongest reduction in weekly itch scores observed with 300 mg dosing. Complete response was higher in the omalizumab group (relative risk, 4.55; P < .00001) and dose dependent, with the highest rates in the 300-mg group. Adverse events were similar in the omalizumab and placebo groups.

A systematic review looked at the efficacy and safety of omalizumab in the pediatric age group (Matin 2016). The authors noted that although the use of omalizumab has been studied vigorously in the adult population there are few heterogeneous studies in children, and only a few ongoing clinical trials with omalizumab exclusively in children. Despite these limitations the authors concluded that in pediatric clinical trials omalizumab was demonstrated to be effective and safe in children and adolescents.
Mitchell (2015) considered chronic spontaneous urticaria unresponsive to non-sedating, second-generation, H1 antihistamines and showed cyclosporine, desloratadine plus dapsone or dipyridamole, montelukast, and omalizumab reduced urticaria activity scores, weals, and pruritus, versus placebo. Optimal treatment doses and durations could not be established with certainty due to varying trial durations, outcome measurement scales, and assessment timings. No adverse events were reported.

A systematic review (Canadian Agency for Drugs and Technologies in Health 2015) sought to assess the beneficial and harmful effects of omalizumab 300 mg per month for up to 6 months on treatment of chronic idiopathic urticaria in adults and adolescents (n=1116 participants) refractory to H1 antihistamine treatment. There was improvement in measures of disease activity and quality of life following treatment with omalizumab when compared with placebo [mean difference (MD) -11.58, 95% confidence interval (CI) -13.39 to -9.77 and MD -13.12, 95% CI -16.30 to -9.95, respectively]. Complete response and partial response were more frequent after treatment with omalizumab [risk ratio (RR) 6.44, 95% CI 3.95-10.49 and RR 4.08, 95% CI 2.98-5.60, respectively]. There was no difference in the proportion of participants reporting adverse events between the omalizumab and placebo treatment groups (RR 1.05, 95% CI 0.96-1.16).

Termeer (2015) proposed a diagnostic and therapeutic management pathway for chronic idiopathic urticaria, including updosing of antihistamines, cyclosporine A, montelukast, and omalizumab. The authors presented an urticaria control test to measure clinical disease-specific outcomes in typical practice.

A systematic review (Carrillo 2014) studied individuals ≥12 years of age (n=1117 patients) diagnosed with refractory urticaria. The therapeutic intervention (omalizumab at different doses) was assessed opposite a placebo control. The primary outcome was symptom improvement according to the weekly score of urticaria severity, the itch severity score, the weekly score of number of urticarial lesions, the dermatology life quality index, and the chronic urticaria quality of life questionnaire. Of the study group 831 received a dose of omalizumab of 75 mg (183 patients, 16.38%), 150 mg (163 patients, 14.59%), 300 mg (437 patients, 39.12%) or 600 mg (21 patients, 1.8%), as a single dose, or every 4 weeks until 24 weeks maximum. Omalizumab 300 mg lowered the weekly scores of urticarial activity in 19.9 vs. 6.9 on placebo (p <0.01), 19 vs 8.5 and 20.7 vs 8.01 in three studies, the weekly itch severity score (-9.2 vs. -3.5, p <0.001, -9.8 vs -5.1, p <0.01, -8.6 vs -4.0 and -9.4 vs -3.63 p <0.001 in four studies), and the percentage of angioedema-free days (omalizumab 95.5% vs. placebo 89.2% p <0.001, and 91.95% vs. 88.1% p <0.001 in two of the studies respectively).

Bernstein (2014), writing on behalf of the American Academy of Allergy, Asthma & Immunology; the American College of Allergy, Asthma & Immunology; and the Joint Council of Allergy, Asthma & Immunology, developed practice guidelines for the diagnosis and management of urticaria. The work provides a step-wise approach for care of chronic idiopathic urticaria. Step-1 is monotherapy with a second-generation antihistamine and avoiding triggers and relevant physical factors. Step-2 includes one or more of the following: increasing the dose of the second generation antihistamine used in Step-1; adding another second generation antihistamine; adding an H2-antagonist; adding a leukotriene receptor antagonist; or adding a first-generation antihistamine to be taken at bedtime. Step-3 involves dose advancement of a potent antihistamine (e.g., hydroxyzine or doxepin) as tolerated. Omalizumab is an option listed as an
alternative agent in Step-4 (the final step) along with cyclosporine or other anti-inflammatory agents, immunosuppressants, or biologics.

A Phase III, multi-center, randomized (n=323), double-blind study (Maurer 2013) evaluated the safety and efficacy of omalizumab over 28 weeks in subjects aged ≥12 years with chronic idiopathic urticaria refractory to H1-antihistamine therapy. At the start, baseline weekly itch-severity scores were approximately 14 in all groups. The mean changes from baseline in the weekly itch-severity scores indicated significant improvement in the group receiving 150 mg of omalizumab (-8.1 ± 6.4; p=0.001) and in those receiving 300 mg of omalizumab (-9.8 ± 6.0; p<0.001). The mean weekly itch-severity scores increased for all omalizumab-treated groups upon termination of treatment to reach values similar to those in the placebo group and did not return to baseline values for the duration of the follow-up. The authors concluded that 150 mg or 300 mg of omalizumab led to improved outcomes in self-reported itch-severity scores.

A multicenter, randomized, double-blind, placebo-controlled study (Kaplan, 2013) evaluated subjects aged 12 to 75 years with chronic idiopathic urticaria on 300 mg of omalizumab who remained symptomatic, despite treatment with H1-antihistamines at up to four times the approved dose plus H2-antihistamines, leukotriene receptor antagonists, or both. The treatment period with omalizumab was 24 weeks followed by a 16-week observation period during which omalizumab was not administered. The mean change from baseline in weekly itch-severity score was 28.6 (95 percent CI, 29.3 to 27.8) in the omalizumab group compared with 24.0 (95 percent CI, 25.3 to 22.7) in the placebo group (p<0.001). This improvement in itch-severity score was sustained to 24 weeks. At week 40, after discontinuation of omalizumab, there were no statistical differences in the weekly itch-severity scores between the omalizumab-treated group and placebo group. Serious adverse events were reported by 23 (6.9%) subjects during the total 40-week study period (18 [7.1%] in the omalizumab-treated group and 5 [6.0%] in the placebo group).

Saini (2011) conducted a randomized, double-blind, placebo-controlled trial to evaluate the efficacy and safety of subcutaneous adjuvant omalizumab in patients (n=319) with chronic idiopathic urticaria who remained symptomatic despite H1 antihistamine treatment. Eligible patients aged 12 through 75 years with refractory chronic idiopathic urticaria were randomized in a double-blind manner to subcutaneous omalizumab 75 mg (n=78), 150 mg (n=80), or 300 mg (n=81) or placebo (n=80) every four weeks for 24 weeks followed by 16 weeks of follow-up. The mean weekly itch severity scores at baseline were fairly balanced across treatment groups and ranged between 13.7 and 14.5 despite use of an H1 antihistamine at an approved dose. Compared with placebo mean weekly itch-severity score was reduced in the treatment group from baseline to week 12 by an additional 2.96 points (95 percent CI: −4.71 to −1.21; p=0.0010), 2.95 points (95 percent CI: −4.72 to −1.18; p=0.0012), and 5.80 points (95 percent CI: −7.49 to −4.10; p < 0.0001) in the omalizumab 75-mg, 150-mg, and 300-mg groups, respectively. Adverse events were noted in 2 (2.9 percent), 3 (3.4 percent), 0, and 4 (5.0 percent) patients in the omalizumab 75-mg, 150-mg, 300-mg, and placebo groups, respectively.

A systematic review (Urgert 2015) inclusive of 1,116 participants found significant decrements in chronic idiopathic urticaria activity and improved quality of life following treatment with omalizumab when compared to placebo. Complete response and partial response was more frequent after treatment with omalizumab. There was no difference in the proportion of participants reporting adverse events between
the omalizumab and placebo treatment groups. The authors concluded there was high-quality evidence to support the safety and effectiveness of omalizumab 300 mg per month for the treatment of chronic idiopathic urticaria.

**Summary of clinical evidence:**

<table>
<thead>
<tr>
<th>Citation</th>
<th>Content, Methods, Recommendations</th>
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<tbody>
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<td>Maurer (2017)</td>
<td>Omalizumab treatment in patients with chronic inducible urticaria</td>
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<td>Omalizumab for the Treatment of Chronic Idiopathic Urticaria</td>
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| Matin (2016) | **Key points:**  
- Systematic review looked at the efficacy and safety of omalizumab in the pediatric age group.  
- The authors noted that although the use of omalizumab has been studied vigorously in the adult population there are few heterogeneous studies in children, and only a few ongoing clinical trials with omalizumab exclusively in children.  
- Despite these limitations the authors concluded that in pediatric clinical trials omalizumab was demonstrated to be effective and safe in children and adolescents. |
| Mitchell (2015) | **Key points:**  
- Trial considered chronic spontaneous urticaria unresponsive to nonsedating, second-generation, H1 antihistamines  
- Showed cyclosporine, desloratadine plus dapsone or dipyridamole, montelukast, and omalizumab reduced urticaria activity scores, weals, and pruritus, versus placebo.  
- Optimal treatment doses and durations could not be established with certainty due to varying trial durations, outcome measurement scales, and assessment timings.  
- No adverse events were reported. |
| Canadian Agency for Drugs and Technologies in Health (2015) | **Key points:**  
- A systematic review sought to assess the beneficial and harmful effects of omalizumab 300 mg per month for up to 6 months on treatment of chronic idiopathic urticaria in adults and adolescents (n=1116 participants) refractory to H1 antihistamine treatment.  
- There was improvement in measures of disease activity and quality of life following treatment with omalizumab when compared with placebo [mean difference (MD) -11·58, 95% confidence interval (CI) -13·39 to -9·77 and MD -13·12, 95% CI -16·30 to -9·95, respectively].  
- Complete response and partial response were more frequent after treatment with omalizumab [risk ratio (RR) 6·44, 95% CI 3·95-10·49 and RR 4·08, 95% CI 2·98-5·60, respectively].  
- There was no difference in the proportion of participants reporting adverse events between the omalizumab and placebo treatment groups (RR 1·05, 95% CI 0·96-1·16). |
| Termeer (2015) | **Key points:**  
- Proposed a diagnostic and therapeutic management pathway for chronic idiopathic urticaria, including updosing of antihistamines, cyclosporine A, montelukast, and omalizumab.  
- The authors presented an urticaria control test to measure clinical disease-specific outcomes in typical practice. |
| Carrillo (2014) | **Key points:**  
- A systematic review studied individuals ≥12 years of age (n=1117 patients) diagnosed with refractory urticaria.  
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<tr>
<td>Bernstein (2014)</td>
<td><strong>Practice parameter: The diagnosis and management of acute and chronic urticaria.</strong></td>
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<tr>
<td>Maurer (2013)</td>
<td><strong>Omalizumab for the treatment of chronic idiopathic or spontaneous urticaria</strong></td>
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- The primary outcome was symptom improvement according to the weekly score of urticaria severity, the itch severity score, the weekly score of number of urticarial lesions, the dermatology life quality index, and the chronic urticaria quality of life questionnaire.
- Of the study group 831 received a dose of omalizumab of 75 mg (183 patients, 16.38%), 150 mg (163 patients, 14.59%), 300 mg (437 patients, 39.12%) or 600 mg (21 patients, 1.8%), as a single dose, or every 4 weeks until 24 weeks maximum.
- Omalizumab 300 mg lowered the weekly scores of urticarial activity in 19.9 vs. 6.9 on placebo (p <0.01), 19 vs 8.5 and 20.7 vs 8.01 in three studies, the weekly itch severity score (-9.2 vs. - 3.5, p <0.001, -9.8 vs -5.1p < 0.01, -8.6 vs -4.0 and -9.4 vs -3.63 p <0.001 in four studies), and the percentage of angioedema-free days (omalizumab 95.5% vs. placebo 89.2% p <0.001, and 91.95% vs. 88.1% p <0.001 in two of the studies respectively).

**Key points:**

- A systematic review inclusive of 1,116 participants found significant decrements in chronic idiopathic urticaria activity and improved quality of life following treatment with omalizumab when compared to placebo.
- Complete response and partial response was more frequent after treatment with omalizumab.
- There was no difference in the proportion of participants reporting adverse events between the omalizumab and placebo treatment groups.
- The authors concluded there was high-quality evidence to support the safety and effectiveness of omalizumab 300 mg per month for the treatment of chronic idiopathic urticaria.

**Key points:**

- The parameters provide a step-care approach for chronic idiopathic urticaria.
- Step-1 is monotherapy with a second-generation antihistamine and avoiding triggers and relevant physical factors.
- Step-2 includes one or more of the following: increasing the dose of the second generation antihistamine used in Step-1; adding another second generation antihistamine; adding an H2-antagonist; adding a leukotriene receptor antagonist; or adding a first-generation antihistamine to be taken at bedtime.
- Step-3 involves dose advancement of a potent antihistamine (e.g., hydroxyzine or doxepin) as tolerated.
- Omalizumab is an option listed as an alternative agent in Step-4 (the final step) along with cyclosporine or other anti-inflammatory agents, immunosuppressants, or biologics.
- The parameters also advocate “stepping-down” at any step once consistent control is achieved.

**Key points:**

- Patients were randomized to either omalizumab at doses of 75 mg, 150 mg, or 300 mg every four weeks or placebo for a treatment period of 12 weeks and a follow-up period of 16 weeks. Patients remained on their baseline licensed doses of H1-antihistamines throughout the trial.
- The primary endpoint was the change in a weekly activity scores from baseline to week 12.
and significantly improved in the omalizumab 150 mg and 300 mg treatment groups compared to placebo.

- Following completion of the active treatment phase, patients in the omalizumab groups had increases in their mean weekly score for the number of hives that reached a similar value to placebo, but did not reach their baseline score.
- Serious adverse events were more common in the omalizumab 300 mg every four weeks group (8 percent) compared to omalizumab 75 mg every four weeks (5 percent) and 150 mg every four weeks (6 percent); the placebo group rate was similar at 9 percent to the 300 mg group.

### Kaplan (2013).

**Omalizumab in patients with symptomatic chronic idiopathic/spontaneous urticaria**

**Key points:**

- Patients enrolled had minimum six-month duration of chronic idiopathic urticaria despite treatment with H1-antihistamines (up to four times the licensed dose) with H2-antihistamines, leukotriene receptor antagonists, or both.
- Efficacies were evaluated using hives, and urticaria activity scores at weeks 12 and 24 and were statistically significantly in favor of omalizumab.
- The number of adverse events was similar between the omalizumab and placebo groups during the treatment phase and the number of serious adverse events was 7.1 percent in the omalizumab compared to 6 percent in the placebo group.

### Saini (2011)

**A randomized, placebo-controlled, dose-ranging study of single-dose omalizumab in patients with H1-antihistamine-refractory chronic idiopathic urticaria**

**Key points:**

- Randomized, double-blind, placebo-controlled trial to evaluate the efficacy and safety of subcutaneous adjuvant omalizumab in patients (n=319) with chronic idiopathic urticaria who remained symptomatic despite H1 antihistamine treatment.
- Eligible patients aged 12 through 75 years with refractory chronic idiopathic urticaria were randomized in a double-blind manner to subcutaneous omalizumab 75 mg (n=78), 150 mg (n=80), or 300 mg (n=81) or placebo (n=80) every four weeks for 24 weeks followed by 16 weeks of follow-up.
- The mean weekly itch severity scores at baseline were fairly balanced across treatment groups and ranged between 13.7 and 14.5 despite use of an H1 antihistamine at an approved dose.
- Compared with placebo mean weekly itch-severity score was reduced in the treatment group from baseline to week 12 by an additional 2.96 points (95 percent CI: −4.71 to −1.21; p=0.0010), 2.95 points (95 percent CI: −4.72 to −1.18; p=0.0012), and 5.80 points (95 percent CI: −7.49 to −4.10; p < 0.0001) in the omalizumab 75-mg, 150-mg, and 300-mg groups, respectively.
- Adverse events were noted in 2 (2.9 percent), 3 (3.4 percent), 0, and 4 (5.0 percent) patients in the omalizumab 75-mg, 150-mg, 300-mg, and placebo groups, respectively.

### References

**Professional society guidelines/other:**

Bernstein JA, Lang DM, Khan DA, et al. 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. Practice parameter: The

**Omalizumab (Xolair): Treatment of Adults and Adolescents (12 Years of Age and above) with Chronic Idiopathic Urticaria** [Internet]. Ottawa (ON): Canadian Agency for Drugs and Technologies in Health; 2015.

**Peer-reviewed references:**


**CMS National Coverage Determinations (NCDs):**

No NCDs identified as of the writing of this policy.

**Local Coverage Determinations (LCDs):**

Xolair® (Omalizumab) L33924. Effective 10/01/2015. CMS Medicare Coverage Database website. https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=33924&ver=4&Cov erageSelection=Both&ArticleType=All&P olicyType=Final&s=All&KeyWord=Xolair%u00ae+(Omalizumab)&KeyWordLookUp=Title&KeyWordSearchType=And&list_type=ncd&bc =gAAAAACAAAAAAA%3d%3d&. Accessed on October 3, 2017.

**Commonly submitted codes**

Below are the most commonly submitted codes for the services/items subject to this policy. This is not an exhaustive list of codes. Providers are expected to consult the appropriate coding manuals and bill accordingly.

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
<th>Comments</th>
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<tr>
<td>L50.8</td>
<td>Chronic idiopathic urticaria</td>
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<tr>
<td>J2357</td>
<td>Xolair 5 mg</td>
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</table>

**Appendix A**
PerformRx Prior Authorization Criteria for Xolair (omalizumab)

Xolair (omalizumab) Formulary Status: Non Formulary

Initial PA Criteria for Asthma:

- Provider is a pulmonologist or allergist, or provider has consulted with one of these specialists (provide documentation of consult)
- Patient has history ≥ 1 year of moderate to severe asthma, and drug is indicated for age of patient at an approved dose
- The patient has a documented baseline FEV1 < 80% of predicted or FEV1/FVC that has been reduced by at least 5% of normal for the patient age range (see Table 1 below).
- Patient has at least ONE of the following:
  - Daily use of inhaled short acting B2 agonist
  - Daily or continual symptoms
  - Limited physical activity due to asthma exacerbations
  - Nighttime symptoms > once per week
- Patient continues to have significant symptoms (e.g. hospital admission, emergency room visits, and/or the severe of asthma exacerbations) AND IS COMPLIANT on the following (or has medical reason for not utilizing) ALL of the following agents:
  - High-dose inhaled corticosteroid with long-acting B2 agonist
  - A leukotriene receptor antagonist OR theophylline
  - The patient has a positive documented immediate response on RAST test and/or skin prick test to at least 1 common allergen (e.g. dermatophagoides farinae, dermatophagoides pteronyssinus, dog, cat, or cockroach) and is an asthma trigger (copy of results required)
  - The patient has received immunotherapy and the patient had documented clinical asthma recurrence/persistence precipitated by the allergen(s) for which the patient is receiving immunotherapy that had resulted in a hospital admission or emergency room visit OR a medical reason has been provided for not using immunotherapy (e.g. severe, unstable asthma or severe, systemic injection reactions)
  - Environmental measures were attempted to avoid and/or minimize exposure to allergen asthma triggers
  - The patient is not currently receiving medication that could cause bronchospasm (e.g. beta blocker or NSAIDs), or a medical reason was provided that the medication is not causing worsening in asthma symptoms.

Initial PA Criteria for Chronic Idiopathic Urticaria:

- Provider is a pulmonologist or allergist, immunologist or dermatologist, or provider has consulted with one of these specialists (provide documentation of consult)
- Provider is a pulmonologist or allergist, or provider has consulted with one of these specialists (provide documentation of consult)
- Drug is indicated for age of patient at an approved dose
- The patient has a documented history of urticaria for at least 3 months
• The patient requires oral steroids to control symptoms
• The patient remains symptomatic despite adequate trials (or has medical reason for not utilizing) ALL of the following:
  o TWO formulary H1 antihistamines (1st generation-e.g. hydroxyzine, cyproheptadine and 2nd generation –loratidine, cetirizine)
  o ONE formulary H2 antihistamine (e.g. famotidine, ranitidine)
  o Montelukast

If all of the above conditions are met per indication, the request will be approved with a four-month duration. If all of the above criteria are not met, the request is referred to a Medical Director/Clinical Reviewer for medical necessity review.

Re-Authorization PA Criteria for Both Indications:
• Prescriber has re-evaluated member and recommends continuation of therapy
• Documentation submitted indicates that the member has significantly benefited from medication (e.g. decrease exacerbations, reduction in use of oral steroids)

If all of the above conditions are met per indication, the request will be approved with a 6-month duration; if all of the above criteria are not met, the request is referred to a Medical Director/Clinical Reviewer for medical necessity review.

<table>
<thead>
<tr>
<th>Table 1: Normal FEV1/FVC</th>
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<tbody>
<tr>
<td>Patient Age</td>
</tr>
<tr>
<td>--------------</td>
</tr>
<tr>
<td>8-19</td>
</tr>
<tr>
<td>20-39</td>
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<tr>
<td>40-59</td>
</tr>
<tr>
<td>60-80</td>
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Review/Revision Date: 7/2017
PARP approved 8/2017