Corporate Medical Policy: Omalizumab (Xolair®) **"Notification"** **POLICY EFFECTIVE OCTOBER 1, 2025**

Restricted Product(s):

- omalizumab (Xolair®) subcutaneous injection for administration by a healthcare professional

FDA Approved Use:

- For treatment of moderate to severe persistent asthma in patients 6 years of age and older with a positive skin test or in vitro reactivity to a perennial aeroallergen and symptoms that are inadequately controlled with inhaled corticosteroids
- For treatment of chronic spontaneous urticaria in patients 12 years of age and older who remain symptomatic despite H1 antihistamine treatment
- For add-on maintenance treatment of chronic rhinosinusitis with nasal polyps in patients 18 years of age and older with inadequate response to nasal corticosteroids
- For treatment of IgE-mediated food allergy in patients aged 1 year and older for the reduction of allergic reactions (Type 1), including anaphylaxis, that may occur with accidental exposure to one or more foods. To be used in conjunction with food allergen avoidance.
- Limitations of use: Not for emergency treatment of allergic reactions, including anaphylaxis; not for treatment of other forms of urticaria; not for relief of acute bronchospasm or status asthmaticus

Criteria for Medical Necessity:

The restricted product(s) may be considered medically necessary when the following criteria are met:

Initial Criteria for Approval:

1. The patient has a diagnosis of **moderate to severe persistent asthma**; **AND**
    a. The patient is 6 years of age or older; **AND**
        i. For patients 6 to 11 years of age, the pre-treatment IgE level is between 30 and 1300 IU/mL **[medical record documentation required]**; **OR**
        ii. For patients 12 years of age or older, the pre-treatment IgE level is between 30 and 700 IU/mL **[medical record documentation required]**; **AND**
    b. The patient has a positive skin test or in vitro reactivity to a perennial aeroallergen; **AND**
    c. The patient is currently treated with and adherent to maximally tolerated conventional therapies to include BOTH of the following:
        i. An inhaled corticosteroid regimen for the past 3 months **[medical record documentation required]**; **OR**

1. The patient has a clinical intolerance/contraindication to ALL inhaled corticosteroids **[medical record documentation required]**; **AND**

ii. A regimen containing either a long-acting beta-2 agonist (LABA), leukotriene receptor antagonist (LTRA), long-acting muscarinic antagonist (LAMA), theophylline, or zileuton for the past 3 months **[medical record documentation required]**; **OR**

1. The patient has a clinical intolerance/contraindication to ALL of the following: long-acting beta-2 agonist, leukotriene receptor antagonist, long-acting muscarinic antagonist, and zileuton **[medical record documentation required]**; **AND**

d. The patient has a history of inadequately controlled asthma despite adherence to asthma control therapy as demonstrated by ONE of the following **[medical record documentation required]**:

i. Frequent severe asthma exacerbations requiring two or more courses of systemic corticosteroids (steroid burst) within the past 12 months; **OR**

ii. Serious asthma exacerbations requiring hospitalization, mechanical ventilation, or visit to the emergency room or urgent care within the past 12 months; **OR**

iii. Controlled asthma that worsens when the doses of inhaled and/or systemic corticosteroids are tapered; **OR**

iv. The patient has baseline (prior to therapy with the requested agent) Forced Expiratory Volume (FEV1) that is less than 80% of predicted; **AND**

e. The patient will continue asthma control therapy [e.g., inhaled corticosteroids (ICS), ICS/LABA, LTRA, LAMA, theophylline] in combination with the requested agent; **OR**

2. The patient has a diagnosis of **chronic spontaneous urticaria (CSU)** (otherwise known as chronic idiopathic urticaria [CIU]); **AND**

a. The patient is 12 years of age or older; **AND**

b. The patient has experienced hives and itching for at least 6 weeks **[medical record documentation required]**; **AND**

c. If the patient is currently treated with medications known to cause or worsen urticaria, then ONE of the following:

i. The prescriber has reduced the dose or discontinued any medications known to cause or worsen urticaria (e.g., NSAIDs); **OR**

ii. There is support that a reduced dose or discontinuation of any medication(s) known to cause or worsen urticaria is NOT clinically appropriate for the patient; **AND**

d. ONE of the following:

i. BOTH of the following:

1. The patient has tried and had an inadequate response to the FDA labeled maximum dose of ONE second generation H1 antihistamine (e.g., cetirizine, levocetirizine, fexofenadine, loratadine, desloratadine) for at least a 2-week trial **[medical record documentation required]**; **AND**

2. ONE of the following:

a. The patient has tried and had an inadequate response to a dose titrated equivalent to at least 2 times the FDA labeled maximum dose **[medical record documentation required]**; **OR**
b. The patient cannot be treated with a dose titrated equivalent to at least 2 times the FDA labeled maximum dose **[medical record documentation required]**; **OR**

ii. The patient has an intolerance or hypersensitivity to second generation H1 antihistamine therapy **[medical record documentation required]**; **OR**
iii. The patient has an FDA labeled contraindication to ALL second generation H1 antihistamines **[medical record documentation required]**; **AND**

e. The requested dose is within the FDA labeled dosing for the requested indication AND does NOT exceed 300 mg every 4 weeks; **OR**

3. The patient has a diagnosis of **chronic rhinosinusitis with nasal polyps (CRSwNP)**; **AND**
   a. The patient is 18 years of age or older; **AND**
   b. The patient has tried and had an inadequate response to OR has a clinical contraindication or intolerance to Xhance (fluticasone propionate nasal spray) **[medical record documentation required]**; **OR**
   c. The patient has tried and had an inadequate response to OR has a clinical contraindication or intolerance to oral systemic corticosteroids within the previous 6 months **[medical record documentation required]**; **AND**
   d. ONE of the following:
      i. The patient has had prior surgery for nasal polyps **[medical record documentation required]**; **OR**
      ii. The patient is not a candidate for sinus surgery **[medical record documentation required]**; **AND**
   e. The patient will NOT be using Xolair (omalizumab) in combination with Xhance (fluticasone propionate nasal spray); **AND**
   f. ONE of the following:
      i. The patient is currently being treated with an over-the-counter intranasal steroid; **OR**
      ii. The patient has a clinical contraindication or intolerance to ALL intranasal steroids **[medical record documentation required]**; **OR**

4. The patient has a diagnosis of **IgE-mediated food allergy**; **AND**
   a. The patient is 1 year of age or older; **AND**
   b. The requested agent will be used in conjunction with food allergen avoidance; **AND**

5. The patient is NOT being treated for acute bronchospasm, status asthmaticus, allergic rhinitis, or emergency allergic reactions, including anaphylaxis; **AND**
6. The prescriber is a specialist in the area of the patient's diagnosis (e.g., allergist, pulmonologist, immunologist, otolaryngologist) or has consulted with a specialist in the area of the patient's diagnosis; **AND**

7. The patient will NOT receive the requested agent in combination with another biologic immunomodulator agent used for the same indication [e.g., benralizumab (Fasenra), dupilumab (Dupixent), mepolizumab (Nucala), reslizumab (Cinqair)]; **AND**
8. The patient does NOT have any FDA labeled contraindications to the requested agent; **AND**
9. The patient has a physical or cognitive limitation that makes the utilization of a self-administered formulation unsafe or otherwise not feasible, as demonstrated by BOTH of the following **[medical record documentation required]**:
    a. Inability to self-administer the medication; **AND**
    b. Lack of caregiver or support system for assistance with administration of self-administered products; **AND**
10. The requested quantity does NOT exceed the maximum units allowed for the duration of approval (see table below); **AND**
11. For requests for injection or infusion administration of the requested medication in an **inpatient or outpatient hospital setting,** Site of Care Criteria applies (outlined below)*

    Duration of Approval: 365 days (1 year)

Continuation Criteria for Approval:

1. The patient has been previously approved for omalizumab (Xolair) through Blue Cross NC initial criteria for approval; **OR**
2. The patient would have met initial criteria for approval at the time they started therapy; **AND**
3. For patients with a diagnosis of **asthma**:
    a. The patient has had improvements or stabilization with the requested agent from baseline (prior to therapy with the requested agent) as indicated by ONE or more of the following **[medical record documentation required]**:
        i. The patient has had a decrease in utilization of rescue medications; **OR**
        ii. The patient has had a decrease in frequency of exacerbations (defined as worsening of asthma that requires an increase in ICS dose or treatment with systemic corticosteroids); **OR**
        iii. The patient has had an increase in predicted FEV1 from pretreatment baseline; **OR**
        iv. The patient has had a reduction in reported asthma-related symptoms, such as, asthmatic symptoms upon awakening, coughing, fatigue, shortness of breath, sleep disturbance, or wheezing; **AND**
    b. The patient is currently treated and is compliant with asthma control therapy [e.g., inhaled corticosteroids (ICS), ICS/long-acting beta-2 agonist (ICS/LABA), leukotriene receptor antagonist (LTRA), long-acting muscarinic antagonist (LAMA), theophylline]; **OR**
4. For patients with **chronic spontaneous urticaria (CSU)** (otherwise known as chronic idiopathic urticaria [CIU]):
    a. The patient has demonstrated positive clinical response while using the requested agent (e.g., reduction in reported itch severity and/or hive count) **[medical record documentation required]**; **AND**
    b. The requested dose is within the FDA labeled dosing for the requested indication AND does NOT exceed 300 mg every 4 weeks; **OR**
5. For patients with **chronic rhinosinusitis with nasal polyps (CRSwNP)**:

   a. The patient has been on and adherent to an over-the-counter intranasal steroid since starting omalizumab (Xolair) therapy **[medical record documentation required]**; **OR**
   b. The patient has a clinical contraindication or intolerance to ALL intranasal steroids **[medical record documentation required]**; **OR**
6. For patients with **IgE-mediated food allergy**, the patient has demonstrated the following while using the requested agent **[medical record documentation required]**:
   a. Reduction in reported dose-limiting symptoms (e.g., moderate to severe skin, respiratory, or gastrointestinal symptoms) to the food allergen; **AND**
   b. The patient will continue to use the requested agent in conjunction with food allergen avoidance; **AND**
7. The patient is NOT being treated for acute bronchospasm, status asthmaticus, allergic rhinitis, or emergency allergic reactions, including anaphylaxis; **AND**
8. The prescriber is a specialist in the area of the patient's diagnosis (e.g., allergist, pulmonologist, immunologist, otolaryngologist) or has consulted with a specialist in the area of the patient's diagnosis; **AND**
9. The patient will NOT receive the requested agent in combination with another biologic immunomodulator agent used for the same indication [e.g., benralizumab (Fasenra), dupilumab (Dupixent), mepolizumab (Nucala), reslizumab (Cinqair)]; **AND**
10. The patient does NOT have any FDA labeled contraindications to the requested agent; **AND**
11. The patient has a physical or cognitive limitation that makes the utilization of a self-administered formulation unsafe or otherwise not feasible, as demonstrated by BOTH of the following **[medical record documentation required]**:
    a. Inability to self-administer the medication; **AND**
    b. Lack of caregiver or support system for assistance with administration of self-administered products; **AND**
12. The requested quantity does NOT exceed the maximum units allowed for the duration of approval (see table below); **AND**
13. For requests for injection or infusion administration of the requested medication in an **inpatient or outpatient hospital setting,** Site of Care Criteria applies (outlined below)*

Duration of Approval: 365 days (1 year)

FDA Label Reference				
Medication	**Indication*,^**	**Dosing**	**HCPCS**	**Maximum Units***
omalizumab (Xolair®) subcutaneous (SC) injection	Moderate to severe persistent asthma in patients ≥6 years old	SC: 75 mg to 375 mg every 2 or 4 weeks. Dose and frequency determined by pre-treatment serum total IgE level.	J2357	1950
	Chronic spontaneous urticaria in patients ≥12 years old	SC: 150 mg or 300 mg every 4 weeks		780
	Chronic rhinosinusitis with nasal polyps in patients ≥18 years old	SC: 75 mg to 600 mg every 2 or 4 weeks. Dosing and frequency determined by pre-treatment serum total IgE level.		3120
	IgE-mediated food allergy in patients ≥1 year old	SC: 75 mg to 600 mg every 2 or 4 weeks. Dosing and frequency determined by pre-treatment serum total IgE level.		3120

* Omalizumab is not indicated for treatment of other allergic conditions, other forms of urticaria, relief of acute bronchospasms, or status asthmaticus.
^Omalizumab has not been studied for use in combination with Cinqair (reslizumab) or Nucala (mepolizumab)

***Maximum units allowed for duration of approval**

***Site of Care Medical Necessity Criteria**

1. For requests for injection or infusion administration in an **inpatient setting**, the injection or infusion may be given if the above medical necessity criteria are met AND the inpatient admission is NOT for the sole purpose of administering the injection or infusion; **OR**
2. For requests for injection or infusion administration in an **outpatient hospital setting**, the injection or infusion may be given if the above medical necessity criteria are met AND ONE of the following must be met:
    a. History of mild adverse events that have not been successfully managed through mild pre-medication (e.g., diphenhydramine, acetaminophen, steroids, fluids, etc.); **OR**
    b. Inability to physically and cognitively adhere to the treatment schedule and regimen complexity; **OR**

   c. New to therapy, defined as initial injection or infusion OR less than 3 months since initial injection or infusion; **OR**
   d. Re-initiation of therapy, defined as ONE of the following:
      i. First injection or infusion after 6 months of no injections or infusions for drugs with an approved dosing interval less than 6 months duration; **OR**
      ii. First injection or infusion after at least a 1-month gap in therapy outside of the approved dosing interval for drugs requiring every 6 months dosing duration; **OR**
   e. Requirement of a change in the requested restricted product formulation; **AND**
3. If the Site of Care Medical Necessity Criteria in #1 or #2 above are not met, the injection or infusion will be administered in a **home-based infusion** or physician office setting with or without supervision by a certified healthcare professional.

References: all information referenced is from FDA package insert unless otherwise noted below.

Policy Implementation/Update Information: Criteria and treatment protocols are reviewed annually by the Blue Cross NC P&T Committee, regardless of change. This policy is reviewed in Q2 annually.

October 2025: Criteria change: For CRSwNP indication continuation criteria, added required medical record documentation for having been on and adherent to an over-the-counter intranasal steroid since starting Xolair therapy. **Policy notification given 8/1/2025 for effective date 10/1/2025**.
July 2025: Criteria change: For asthma initial criteria: Adjusted formatting to create a separate criteria section with required medical record documentation added for current, adherent treatment with maximally tolerated conventional therapies for the past 3 months with both an inhaled corticosteroid regimen and a regimen containing a LABA, LTRA, LAMA, theophylline, or zileuton. Added parameters for demonstration of inadequate asthma control despite adherence to asthma control therapy, with required medical record documentation. Added requirement that patient will continue asthma control therapy in combination with the requested agent to align with FDA label as add-on maintenance treatment. For asthma continuation criteria: Adjusted formatting for demonstration of improvement or stabilization from baseline for clarity with no change to policy intent, and added requirement that patient is currently treated and compliant with asthma control therapy. For urticaria initial criteria: Added requirement of symptoms for at least 6 weeks with required medical record documentation. Added required dose reduction or discontinuation of medications known to cause/worsen urticaria, or that dose reduction/discontinuation is not clinically appropriate. Reformatted required trial of a second generation H1 antihistamine. For urticaria continuation criteria: Removed requirement of decreased rescue/controller medication utilization and exacerbation frequency. Adjusted formatting for demonstration of positive clinical response such as reduction in itch severity/hive count. Added requirement that dose is within FDA labeling and does not exceed 300 mg every 4 weeks. Added no presence of FDA labeled contraindications to both initial and continuation criteria for all indications. Other minor updates made throughout policy for clarity with no change to policy intent. **Policy notification given 5/2/2025 for effective date 7/1/2025**.

March 2024: Criteria change: Added new indication for Xolair in adult and pediatric patients 1 year and older with IgE-mediated food allergy for reduction of allergic reactions, with corresponding criteria and dosing table updates and added maximum units.
January 2023: Criteria update: Added requirement within initial criteria for asthma indication that patient must be adherent to use of a medium dose inhaled corticosteroid with combination therapy. Minor formatting adjustments made to policy. **Policy notification given 11/1/2022 for effective date 1/1/2023**.
July 2022: Criteria change: Updated step therapy requirement through second generation H1 antihistamine and included maximum dosing for chronic idiopathic urticaria. **Policy notification given 5/2/2022 for effective date 7/1/2022**.
May 2022: Criteria update: Updated chronic rhinosinusitis with nasal polyposis indication to allow trial and failure of Xhance OR oral systemic corticosteroids.
January 2022: Criteria change: Adjusted criteria for chronic rhinosinusitis with nasal polyposis to allow for patients who are not a candidate for sinus surgery.
January 2022: Criteria change: Added requirement for use of the self-administered product unless certain criteria are met. For nasal polyposis indication: added requirement of step through Xhance, removed requirement for nasal saline irrigations, and added requirement for previous surgery for nasal polyps. **Policy notification given 11/4/2021 for effective date 1/4/2022**.
April 2021: Criteria change: Added requirement to be prescribed by or in consultation with a specialist; added maximum units; medical policy formatting change. **Policy notification given 2/26/2021 for effective date 4/28/2021**.
*Further historical criteria changes and updates available upon request from Medical Policy and/or Corporate Pharmacy.