Clinical Policy: Brensocatib (Brinsupri)

Reference Number: CP.PMN.303
Effective Date: 12.01.25
Last Review Date: 11.26
Line of Business: Commercial, HIM/ICHRA, Medicaid

Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Brensocatib (Brinsupri™) is a dipeptidyl peptidase 1 (DPP1) inhibitor.

FDA Approved Indication(s)

Brinsupri is indicated for the treatment of non-cystic fibrosis bronchiectasis in adult and pediatric patients 12 years of age and older.

Policy/Criteria

Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation® that Brinsupri is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Non-Cystic Fibrosis Bronchiectasis (must meet all)**:**

1. Diagnosis of non-cystic fibrosis bronchiectasis evidenced by both of the following (a and b):
   a. Chest computed tomography (CT) scan confirms bronchiectasis;
   b. Member does not have cystic fibrosis;
2. Prescribed by or in consultation with a pulmonologist;
3. Age ≥ 12 years;
4. Provider attestation that member is currently receiving optimal supportive therapy (examples include but are not limited to: airway clearance techniques, pulmonary rehabilitation, mucoactives [e.g., nebulized hypertonic saline, mannitol, dornase alfa, acetylcysteine], antibiotics [e.g., oral – azithromycin, erythromycin; inhaled – tobramycin, aztreonam]);
5. Documentation of one of the following despite at least 3 months of optimal supportive therapy (a or b):
   a. Adults (age ≥ 18 years): Member has had at least 2 pulmonary exacerbations (*see Appendix D*) requiring systemic antibiotics in the last 12 months;
   b. Pediatrics (age 12 to 17 years): Member has had at least 1 pulmonary exacerbation (*see Appendix D*) requiring systemic antibiotics in the last 12 months;
6. Member is not an active smoker as evidenced by recent (within the last 30 days) negative nicotine metabolite (i.e., cotinine) test;

7. Member does not have a primary* diagnosis of asthma or chronic obstructive pulmonary disease;
   **Secondary (comorbid) diagnoses of asthma or chronic obstructive pulmonary disease are allowable*
8. Dose does not exceed 25 mg (1 tablet) per day.

Approval duration: 12 months

B. Other diagnoses/indications (must meet 1 or 2)**:**

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace/ICHRA) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace/ICHRA, and CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace/ICHRA) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace/ICHRA, and CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace/ICHRA, and CP.PMN.53 for Medicaid.

II. Continued Therapy

A. Non-Cystic Fibrosis Bronchiectasis (must meet all)**:**

1. Member meets one of the following (a or b):
   a. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
   b. Member is currently receiving medication and is enrolled in a state and product with continuity of care regulations (*refer to state specific addendums for CC.PHARM.03A and CC.PHARM.03B)*;
2. Member is responding positively to therapy;
3. If request is for a dose increase, new dose does not exceed 25 mg (1 tablet) per day.

Approval duration: 12 months

B. Other diagnoses/indications (must meet 1 or 2)**:**

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace/ICHRA) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace/ICHRA, and CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace/ICHRA) or PDL (Medicaid), the non-formulary policy for the

relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace/ICHRA, and CP.PMN.16 for Medicaid; or

2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace/ICHRA, and CP.PMN.53 for Medicaid.

III. Diagnoses/Indications for which coverage is NOT authorized:

A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies – CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace/ICHRA, and CP.PMN.53 for Medicaid or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key
CT: computed tomography
DPP1: dipeptidyl peptidase 1
FDA: Food and Drug Administration

Appendix B: Therapeutic Alternatives
Not applicable

Appendix C: Contraindications/Boxed Warnings
None reported

Appendix D: General Information

- In the pivotal ASPEN study (NCT04594369), pulmonary exacerbations were defined as worsening of 3 or more of the following major symptoms over 48 hours, resulting in a healthcare provider's decision to prescribe systemic antibiotics: increased cough, increased sputum volume or change in sputum consistency, increased sputum purulence, increased breathlessness, decreased exercise tolerance, fatigue and/or malaise, and hemoptysis.

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Non-cystic fibrosis bronchiectasis	10 mg or 25 mg PO QD	25 mg/day

VI. Product Availability

Tablets: 10 mg, 25 mg

VII. References

1. Brinsupri Prescribing Information. Bridgewater, NJ: Insmed Incorporated; August 2025. Available at: www.brinsupri.com. Accessed July 13, 2026.
2. Chalmers JD, Burgel P, Daley CL, et al. Phase 3 trial of the DPP-1 inhibitor brensocatib in bronchiectasis. N Engl J Med. 2025; 392(16): 1569-1581.

3. Chalmers JD, Haworth CS, Metersky ML, et al. Phase 2 trial of the DPP-1 inhibitor brensocatib in bronchiectasis. N Engl J Med. 2020; 383(22): 2127-2137.
4. Polverino E, Goeminne PC, McDonnell MJ, et al. European Respiratory Society guidelines for the management of adult bronchiectasis. Eur Respir J. 2017; 50(3): 1700629. doi: 10.1183/13993003.00629-2017.
5. Hill AT, Sullivan AL, Chalmers JD, et al. British Thoracic Society guideline for bronchiectasis in adults. Thorax. 2019; 74(Suppl 1): 1-69.
6. Chang AB, Fortescue R, Grimwood K, et al. European Respiratory Society guidelines for the management of children and adolescents with bronchiectasis. Eur Respir J. 2021; 58(2): 2002990. doi: 10.1183/13993003.02990-2020.
7. Chalmers JD, Haworth CS, Flume P, et al. European Respiratory Society clinical practice guideline for the management of adult bronchiectasis. Eur Respir J. 2025; 66(6): 2501126. doi: 10.1183/13993003.01126-2025.
8. Wasfy JH, Kim K, Touchette DR, et al. Brensocatib for non-cystic fibrosis bronchiectasis: Effectiveness and value; Evidence report. Institute for Clinical and Economic Review. Published September 8, 2025. Available at: https://icer.org/assessment/ncfb-2025/. Accessed July 22, 2026.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created	09.11.25	11.25
4Q 2026 annual review: for diagnosis, added clarification that member does not have cystic fibrosis; added ICHRA line of business; references reviewed and updated.	07.22.26	11.26

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions, and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members, and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note:
For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

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