Brensocatib (BRINSUPRI) in Non-Cystic Fibrosis Bronchiectasis (NCFB)
Criteria for Use
December 2025

VA Pharmacy Benefits Management Services and National Formulary Committee

The following recommendations are based on medical evidence, clinician input, and expert opinion. The content of the document is dynamic and will be revised as new information becomes available. The purpose of this document is to assist practitioners in clinical decision-making, to standardize and improve the quality of patient care, and to promote cost-effective drug prescribing. THE CLINICIAN SHOULD USE THIS GUIDANCE AND INTERPRET IT IN THE CLINICAL CONTEXT OF THE INDIVIDUAL PATIENT. INDIVIDUAL CASES THAT ARE EXCEPTIONS TO THE EXCLUSION AND INCLUSION CRITERIA SHOULD BE ADJUDICATED AT THE LOCAL FACILITY ACCORDING TO THE POLICY AND PROCEDURES OF ITS P&T COMMITTEE AND PHARMACY SERVICES.

The Product Information should be consulted for detailed prescribing information.

See the VA National Formulary Committee Monograph on this drug at the *PBM INTRAnet* site for further information.

Exclusion Criteria

If any of the following are selected, the patient will NOT meet criteria for Brensocatib.

- ☐ Exacerbation/worsening symptoms are primarily due to asthma and/or COPD
- ☐ Actively Smoking
- ☐ Diagnosis of Cystic fibrosis
- ☐ Known or suspected immunodeficiency disorder (history of invasive opportunistic infections)

Monitoring: Gingival and periodontal adverse events have been reported. Patients should be advised to perform routine daily dental hygiene and regular dental checkups are recommended.

Inclusion Criteria

All the following criteria must be selected to meet criteria.

- ☐ Provider is a VA or VA Community Care pulmonologist or designated expert.
- ☐ Chronic cough and/or mucopurulent sputum production for at least 3 months within the past year.
- ☐ Diagnosis of non-cystic fibrosis bronchiectasis (NCFB) confirmed by CT Scan. ^1
- ☐ $\geq$ 2 pulmonary exacerbations requiring antibiotics or $\geq$ 1 severe exacerbation requiring hospitalization in past 12 months.
- ☐ Continues to have exacerbations despite receiving long-term antibiotic therapy (e.g., > 3 months of macrolide or inhaled antipseudomonal antibiotic) with adherence confirmed by review of refill history or unable to take long-term antibiotics. ^2
- ☐ Receiving guideline directed therapies for NCFB including treatment of underlying causes, airway clearance techniques, mucoactive agents, inhalers, pulmonary rehabilitation, etc. as clinically indicated. ^3

^1 Completed within the past 2 years and with no case of pneumonia reported within 12 months of the CT scan.

^2 Azithromycin 250 mg daily or 500 mg three times weekly or inhaled antipseudomonal antibiotic in patients with multiple exacerbations (e.g., $\geq$3 exacerbations annually).

^3 Barker AF, Karamooz E. Non-Cystic Fibrosis Bronchiectasis in Adults. A Review. JAMA 2025;334:253-264.

- Airway clearance techniques vary, and choice of technique is based upon individual patient symptoms, disease severity, patient ability and clinical response. Airway clearance techniques should be taught by physical therapists or other appropriately trained professionals.
- Mucoactive agents (e.g,, nebulized hypertonic [3, 6 or 7%] or normal saline [0.9%]) can be considered in patients with frequent exacerbations, difficulty with sputum expectoration and decreased quality of life despite adherence to airway clearance interventions. Pretreatment with albuterol is recommended to reduce bronchospasm.
- Inhalers: Patients with symptoms secondary to other respiratory conditions, use of long-acting bronchodilators may improve symptoms of breathlessness.
- Pulmonary rehabilitation: Offered to patients with decreased exercise tolerance, exercise capacity or functional limitations due to shortness of breath.

Additional Inclusion Criteria

Select if applicable.

☐ For females who can become pregnant: Counseling provided on potential risks vs benefits of treatment and the use of effective contraception during therapy.

Supplemental Information

- Brensocatib statistically reduced the annualized rate of exacerbations and prolonged the time to first exacerbation vs. placebo. There was NO difference in the rate of severe exacerbations (IV antibiotics or hospitalization) between groups. The effect of brensocatib on daily symptoms or quality of life has not been established.
- The following patients were excluded from the ASPEN study (Phase 3): Patients who were currently smoking, patients with a primary diagnosis of COPD or asthma, bronchiectasis due to cystic fibrosis, patients with immunodeficiency disorders including history of invasive opportunistic infections, patients receiving supplemental oxygen >12 hours a day.
- From the Institute for Economic and Clinical Review (ICER):[1] In the ASPEN Phase 3 trial population, there was not a clear difference between brensocatib and placebo among individuals with FEV1 <50%, BSI =9 (Bronchiectasis Severity Index [BSI] score [ranges from 0 to 26; 0-4=mild; 5-8=moderate; >9=severe disease]), or asthma. Therefore, there remains residual uncertainty about the efficacy of brensocatib among more symptomatic patients with more advanced lung damage and/or asthma. However, subgroups were not tested for interaction.
- Patients interviewed for the ICER report cited the burdens and consequences of antibiotics. Whether brensocatib reduces the need for long-term antibiotics remains an important unresolved question. Patients reported a substantial burden of airway clearance at home as well as limitations on work and travel related to airway clearance as important problems. Whether brensocatib reduces the need for these treatments and/or allows patients with NCFB more flexibility with work, travel, and social activities remains an important unresolved question.
- ICER acknowledges that while reduction in exacerbations is very important for patients, daily symptoms such as fatigue and side effects of medications even when stable are also important. The effect of brensocatib at reducing symptom burden is unclear. The improvement in quality of life as measured by the Quality of Life-Bronchiectasis Respiratory Symptom Scale questionnaire observed in the intervention arms of ASPEN crossed the MCID threshold in terms of change from baseline (8 points) in the 25 mg brensocatib group, but between-group differences were less than what has been considered clinically meaningful in prior NCFB interventional trials (MCID 4 points).

[1]Wasfy JH, Kim K, Touchette DR, McKenna A, Richardson M, Herce-Hagiwara B, Kim S, Philips M, Ollendorf D. Brensocatib for Non-Cystic Fibrosis Bronchiectasis: Effectiveness and Value; Final Report. Institute for Clinical and Economic Review, October 30, 2025. https://icer.org/wp-content/uploads/2025/10/ICER_NCFB-Final-Report_For-Publication_103025.pdf (Accessed October 2025)

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