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ReachMD
www.reachmd.com
info@reachmd.com
(866) 423-7849

GINA Recommendations for Biologic Use in Severe Asthma

Announcer:
You're listening to *On the Frontlines of Asthma* on ReachMD. And now, here's your host, Dr. Alexandria May.

Dr. May:
This is ReachMD, and I'm Dr. Alexandria May. Today I am joined by Mr. Brian Bizik to examine the 2025 strategy report from the Global Initiative for Asthma, also known as GINA, and its recommendations for the use of biologics in patients with severe asthma. Not only is Mr. Bizik a physician assistant with over 20 years of clinical experience, but he also serves as the Respiratory Care Coordinator and an Adjunct Professor for Terry Riley Health Centers. Mr. Bizik, thanks for being here today.

Mr. Bizik:
Thank you, I'm glad to be here.

Dr. May:
So let's begin with some background. GINA's 2025 report reinforces a structured approach to identifying severe asthma: confirming the diagnosis, optimizing inhaled therapy, and addressing modifiable risk factors before escalation. But in your experience, Mr. Bizik, where do breakdowns most often occur in this pathway that delay appropriate treatment?

Mr. Bizik:
It's such an important and overwhelming question when it comes to asthma. GINA's trying to give us a structure: confirm the diagnosis, optimize inhaled therapy, assure compliance, and assure that they can afford the inhalers that you're prescribing. Go through those steps, and if you do escalate therapy appropriately, most patients will be controlled. Now, there's always challenges, changes in weather, and triggers, but if we follow the guidelines and start advanced therapy, constantly assess where the patient is.

I always have two questions: how are you, and how have you been? "Tell me how you are now in the last few weeks. How are you sleeping? Are you coughing at night for no reason when you're not sick? Are there things during the day you can't do? How are you now? And let's talk about how you have been. What have your exacerbations been like? Have you gone to an urgent care—because they don't often tell you if they've gone to urgent care—so have you gone to urgent care? Have you gone to the ER? Have you had flare ups where you had to change your therapy?"

If that's the case, then we may need to adjust things. If they're not doing great either recently or their exacerbation numbers up, then we need to advance therapy. And that's the first big hurdle right there. Providers often don't do that; they have the opportunity and the data that the patient is struggling, but they don't advance. So that's one of the big areas.

But other times, we move a patient on to maximized inhaled therapy, and we hit a wall; they're still struggling. Maybe they have difficult-to-treat asthma or severe asthma, and now, I need to move on. And there's a lot of fear and apprehension about that biologic. It can be a scary word because with some biologics, you have to test for TB before you start. So these are immunosuppressive, and there's a lot of anxiety around that.

So when a patient is advanced and you're following the guidelines and you get to that point where you've done what you can with inhaled therapies, you've assured they're compliant, and you modified some of the risk factors, you need to go on. You need to either move them on or get help if you're not comfortable and get them to somebody that can because we have this whole other side of things after inhaled therapies. Our therapies that are on that side can change patient's lives and control asthma in ways we've never been able to before.

Dr. May:
With that being said, the updated guidance places greater emphasis on identifying type 2 inflammation using biomarkers, like blood eosinophils and FeNO, and recommends repeat testing when results are inconclusive. How is this evolving biomarker-driven approach changing the way you assess patients in practice?

Mr. Bizik:
Yeah. I tell people it's only changed everything—every part of asthma care. Maybe not for the very mild asthma or the exercise-induced bronchospasm, but for everybody else, it's changed. And I was trying to think what it would be like to treat asthma without knowing their eosinophil level. And I don't know where I would go because I need to know if I'm treating somebody with asthma. For type 2 inflammation, which you can do in the family practice or the internal medicine setting, we measure it with a CBC, we get eosinophil levels, an IgE level off a serum test, or FeNO if you have access, which is an exhaled way of measuring type 2 inflammation. These tools are so critical now; I can't really imagine moving forward without them in a patient that's struggling at all.

And I just encourage everyone that if you have at least an eosinophil count in the chart, don't hesitate to look through their labs and go back as far as you can—even if you need to go back seven or eight CBCs if it's an adult patient—and find that level and answer the question: are eosinophils part of this patient story? Is type 2 inflammation part—a lot or a little—of why they're struggling, why they have these various triggers, and why they're struggling this time of year? If it's a child or a high schooler and they get that flare every year in September, is type 2 inflammation part of this patient's story? And you have to know that now because it's so impactful. If we go after that type 2 inflammation, the change is dramatic.

So I encourage you that if that's not something you're used to looking at, go back and look at as many eosinophil levels as you can. If you find one that's elevated, even one that tells you that they have the predisposition for type 2 inflammation. And so maybe you have one that's a 100 or 150, and then you have one in the chart that's 350. That 350 tells you that they have the predisposition. It doesn't mean it's the biggest thing, but it's important to know. And then you can use that to evaluate them based on their symptoms and how they're doing. So you got to get those levels. If you're not comfortable, start looking back, and I think you'll find that it's not too hard to follow through on understanding what type 2 inflammation is doing in the patient and how to monitor that.

Dr. May:
Now GINA continues to position biologics for patients with exacerbations and/or poor symptom control despite optimized high-dose inhaled corticosteroid-LABA therapy. From your perspective, how do you determine that a patient has truly reached that threshold, and how do you avoid delays once they're clearly eligible?

Mr. Bizik:
Yeah, that's the billion-dollar question: When do I know that I need to do something else? When do I need to move on? And it's tough; it's tough for those in internal medicine, family practice, or pediatrics, and it's tough in the pulmonary world. We have this category of medications. We have inhaled medications and oral therapies, and we want to maximize that. We want to advance those, progress through them, and evaluate them. "How are you, and how have you been?" If they're not doing well, we're going to increase the dose or move them from SMART therapy on to twice-a-day therapy. We're moving them ahead.

But if we've done that and we are relatively certain that they're compliant, their inhaler technique is good, we've changed the risk factors that we can, they're still not where you want them to be or where they want to be, they're still struggling, and there's still things they can't do—I just had a patient last week who wants to play softball; that was her thing, and she couldn't despite being on a triple inhaler—that's a case where I say, okay, we have good therapy, but we're not where we need to be in either exacerbations or symptom control. As soon as you get to that point where you really feel like you've maximized inhaled therapy appropriately and you're still not where you want to be goal-wise, either by asking them questions or just talking to them about their history, that's the point in time where you have to say, 'I need to move them ahead.' There's a line in the sand. I've done everything on the left. I've got biologic therapies on this other side. And I need to move them over there. And at the point when that decision is made, then I just encourage providers: don't delay.

Dr. May:
Absolutely. For those just tuning in, this is ReachMD. I'm Dr. Alexandria May, and I'm speaking with Mr. Brian Bizik about current guideline-based standards for integrating biologic therapies into asthma management.

So, Mr. Bizik, let's dig a little deeper into biologic use. GINA notes that different biologics align with distinct clinical and biomarker profiles: for example, eosinophils, FeNO levels, allergic sensitization, or comorbidities like nasal polyps. Knowing that, how do you approach matching the right biologic to the right patient in real-world care?

Mr. Bizik:
It's a really good question and something that we've had workshops on; we have two-hour workshops to address this. We now have

seven biologics for severe asthma, and that's a lot of options. Some of them have requirements—you need to have an eosinophil level over this, some have age requirements, and some are weekly while some are monthly; we have one now that's every six months. So we have therapies that have different requirements and different biomarkers that are included when it comes to the prescribing information. So it can be pretty overwhelming.

Couple of tips. One, if you're comfortable using AI, you can ask AI to make you a chart of the biologics and what the requirements are in the ages, and right then and there, you have a good outline. You can also add in comorbidities. So what about patients with nasal polyps? And it'll help you define which biologics make the most sense for the patient that you're dealing with.

If you're still uncomfortable, you can certainly reach out and get help because these biologics are very good. They're life-changing medications. Nobody in asthma debates that anymore. Sometimes insurance determines which one we go with, which is fine, but for me, the most important thing is to just do that.

Dr. May:
The report also highlights remissions as an important concept in asthma care, while noting that definitions may vary and can occur on or off treatment. How realistic do you think remission is as a goal in severe asthma today, and what role do biologics play in helping patients move toward it?

Mr. Bizik:
We don't all agree on the definition, but think about it: a year in your patient's life with no oral steroids or significant flares and they can do what they want to do—they sleep well, they're not using the rescue inhaler, and they're doing all of these things—it's a very real possibility for most of our patients with asthma and even a good percentage of our patients with difficult-to-treat or severe asthma. It is a realistic thing for these patients. It takes diligence and compliance—getting help from the insurance companies as well as Medicare and Medicaid being willing to supply these medications—so everybody has to do their part. But when everything clicks, this is a very realistic goal for a lot of our patients. And ultimately, it means their disease level is turned down and they're not having the daily inflammation that was part of their life previously. So it can be a life-changing, wonderful thing for our patients, and it is a realistic goal for many.

Dr. May:
As we come to the end of our conversation, Mr. Bizik, what do you think are the most important takeaways from GINA's 2025 strategy report, and how do you see them being integrated into asthma care to improve long-term outcomes?

Mr. Bizik:
I'm thankful that we have GINA. If anybody from GINA's hearing this, thank you for what you do because it is such a helpful guideline. It's updated annually, it's structured, and it just helps everything. And what GINA has said over the last few years is they've made a big deal of not using bronchodilators by themselves. We've made that change, and a very important change recently was SMART therapy and the data behind SMART therapy. So we've done those things, which are great.

This last year, GINA also added a section on how to diagnose pediatric patients who you can't get spirometry on. Not being afraid of that diagnosis, but seeing a patient who meets criteria, treating them, and monitoring the impact—that was a big part of GINA last year. But the other huge part is that we can personalize care for asthma patients. By doing something as simple as a CBC or a FeNO test, I can understand how much type 2 inflammation is in their life, and then I can adjust therapy to match that. And if I need to, I can move on to a biologic that could impact that.

So personalized care, getting the diagnosis right, continuing to emphasize compliance—inhalers are hard; I think inhalers are the hardest intervention for any common disease state that we have. So make sure people know that and reassess that every few months; you can't just do it once and then be done, and GINA reinforces that as well—so helping patients' compliance, doing what they can with inhalers, and if need be, advancing to biologic therapy if that makes sense for that particular patient.

Dr. May:
That's a great comment for us to think on as we come to the end of today's program. I want to thank my guest, Mr. Brian Bizik, for joining me to explore how current recommendations are shaping the use of biologics in asthma care. Mr. Bizik, it was great having you on the program.

Mr. Bizik:
Thank you for having me. It's exciting times in asthma therapy, and it's always fun to talk about it.

Announcer:
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