Clinical Policy: Mepolizumab (Nucala)

Reference Number: HIM.PA.175
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Line of Business: HIM

Coding Implications
Revision Log

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

Description

Mepolizumab (Nucala®) is an interleukin-5 antagonist monoclonal antibody (IgG1 kappa).

FDA Approved Indication(s)

Nucala is indicated for:

- Add-on maintenance treatment of patients with severe asthma aged 6 years and older, and with an eosinophilic phenotype.
- Add-on maintenance treatment of chronic rhinosinusitis with nasal polyps (CRSwNP) in adult patients 18 years of age and older with inadequate response to nasal corticosteroids.
- Add-on maintenance treatment of adult patients with inadequately controlled chronic obstructive pulmonary disease (COPD) and an eosinophilic phenotype.
- Treatment of adult patients with eosinophilic granulomatosis with polyangiitis (EGPA).
- Treatment of adult and pediatric patients aged 12 years and older with hypereosinophilic syndrome (HES) for ≥ 6 months without an identifiable non-hematologic secondary cause.

Limitation(s) of use: Nucala is not indicated for the relief of acute bronchospasm or status asthmaticus.

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 Nucala is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Severe Asthma (must meet all)**:**

1. Diagnosis of asthma;
2. Member has an absolute blood eosinophil count ≥ 150 cells/mcL within the past 3 months;
3. Prescribed by or in consultation with a pulmonologist, immunologist, or allergist;
4. Age ≥ 6 years;

5. Member has experienced ≥ 2 exacerbations with in the last 12 months, requiring one of the following (a or b), despite adherent use of controller therapy (i.e., medium- to high-dose inhaled corticosteroid [ICS] plus a long acting beta-2 agonist [LABA] or ICS plus one additional asthma controller medication):
   a. Oral/systemic corticosteroid treatment (or increase in dose if already on oral corticosteroid);
   b. Urgent care/emergency room (ER) visit or hospital admission;
6. Failure of Dupixent® and Fasenra®, each used for ≥ 4 consecutive months at up to maximally indicated doses, unless clinically significant adverse effects are experienced or both are contraindicated;^
   **Prior authorization may be required for Dupixent and Fasenra*
   ^For Illinois HIM requests, the step therapy requirements above do not apply as of 1/1/2026 per IL HB 5395
7. Nucala is prescribed concurrently with an ICS plus either a LABA or LTRA;
8. Nucala is not prescribed concurrently with Cinqair®, Fasenra®, Dupixent®, Xolair®, or Tezspire®;
9. Dose does not exceed (a or b):
   a. Age 6 to 11 years: 40 mg every 4 weeks;
   b. Age ≥ 12 years: 100 mg every 4 weeks.

Approval duration: 12 months

B. Eosinophilic Granulomatosis with Polyangiitis (formerly Churg-Strauss) (must meet all)**:**

1. Diagnosis of EGPA (formerly Churg-Strauss) with both of the following (a and b):
   a. Active, non-severe disease;*
      **Non-severe disease is defined as vasculitis without life- or organ-threatening manifestations. Examples of symptoms in patients with non-severe disease include rhinosinusitis, asthma, mild systemic symptoms, uncomplicated cutaneous disease, and mild inflammatory arthritis.*
   b. Eosinophilia as evidenced by eosinophils > 1 x 10^9/L and/or > 10% of leukocytes within the past 3 months;
2. Prescribed by or in consultation with a pulmonologist, rheumatologist, immunologist, or nephrologist;
3. Age ≥ 18 years;
4. Failure of a 4-week trial of a glucocorticoid (*see Appendix B*), unless contraindicated or clinically significant adverse events are experienced;
5. Failure of a ≥ 4 consecutive month trial of Fasenra, used at up to maximally indicated doses, unless contraindicated or clinically significant adverse effects are experienced;^
   **Prior authorization may be required for Fasenra*
   ^For Illinois HIM requests, the step therapy requirements above do not apply as of 1/1/2026 per IL HB 5395
6. Nucala is not prescribed concurrently with Cinqair, Fasenra, Dupixent, Xolair, or Tezspire;
7. Dose does not exceed 300 mg every 4 weeks.

Approval duration: 12 months

C. Hypereosinophilic Syndrome (must meet all)**:**
1. Diagnosis of HES with all of the following characteristics (a, b, and c):
   a. FIP1L1-PDGFRα negative;
   b. Does not have a non-hematologic secondary cause (e.g., drug sensitivity, parasite helminth infection, HIV infection, non-hematological malignancy);
   c. Uncontrolled, defined as a history of ≥ 2 flares (*see Appendix D*) within the past 12 months;
2. Prescribed by or in consultation with a hematologist, dermatologist, or immunologist;
3. Age ≥ 12 years;
4. Member has a blood eosinophil count ≥ 1,000 cells/mcL within the past 3 months;
5. Failure of a 2-month trial of a corticosteroid (*see Appendix B*) within one of the following time frames (a or b), unless contraindicated or clinically significant adverse events are experienced:
   a. Within the last 6 months;
   b. Within the last year if the member's current HES baseline therapy includes interferon-alfa, cyclosporine, azathioprine, hydroxyurea, or imatinib;
6. Nucala is prescribed concurrently with baseline HES therapy (e.g., oral corticosteroids, immunosuppressive therapy);
7. Nucala is not prescribed concurrently with Cinqair, Fasenra, Dupixent, Xolair, or Tezspire;
8. Dose does not exceed 300 mg every 4 weeks.

Approval duration: 12 months

D. Chronic Rhinosinusitis with Nasal Polyps (must meet all)**:**
1. Diagnosis of CRSwNP with documentation of all of the following (a, b, and c):
   a. Presence of nasal polyps;
   b. Disease is bilateral;
   c. Member has experienced signs and symptoms (e.g., nasal congestion/blockage/ obstruction, loss of smell, rhinorrhea) for ≥ 12 weeks;
2. Prescribed by or in consultation with an allergist, immunologist, or otolaryngologist;
3. Age ≥ 18 years;
4. Member has required the use of systemic corticosteroids for symptom control within the last 2 years, unless contraindicated or clinically significant adverse effects are experienced *(see Appendix B for examples)*;
5. Failure of maintenance therapy with at least two intranasal corticosteroids, one of which must be Xhance™*, each used for ≥ 4 weeks, unless contraindicated or clinically significant adverse effects are experienced *(see Appendix B for examples)*;
   **For Illinois HIM requests, the step therapy requirement for use of Xhance above does not apply as of 1/1/2026 per IL HB 5395; any two intranasal corticosteroids may be tried*
6. Failure of a ≥ 4 consecutive month trial of Dupixent, used at up to maximally indicated doses, unless contraindicated or clinically significant adverse effects are experienced;^
   **Prior authorization may be required for Dupixent*
   ^For Illinois HIM requests, the step therapy requirements above do not apply as of 1/1/2026 per IL HB 5395

7. Nucala is prescribed concurrently with an intranasal corticosteroid, unless contraindicated or clinically significant adverse effects are experienced *(see Appendix B for examples)*;
8. Nucala is not prescribed concurrently with Cinqair, Dupixent, Fasenra, Xolair, or Tezspire;
9. Dose does not exceed 100 mg every 4 weeks.

Approval duration: 12 months

E. Chronic Obstructive Pulmonary Disease (must meet all):

1. Diagnosis of COPD as evidenced by one of the following (a or b):
   a. Postbronchodilator ratio of the forced expiratory volume in 1 second (FEV_1)/forced vital capacity (FVC) < 0.7;
   b. Postbronchodilator $FEV_1 \geq 20$ % and ≤ 80% of predicted normal;
2. Age ≥ 18 years;
3. Documentation of eosinophilic phenotype with blood eosinophil count ≥ 150 cells/µL at time of request or ≥ 300 cells/µL in the past 12 months;
4. Member has history of ≥ 2 moderate or ≥ 1 severe exacerbations within the past 12 months;
5. Member meets one of the following (a or b, *see Appendix B*), unless clinically significant adverse effects are experienced or all are contraindicated:
   a. Failure of triple inhaled therapy consisting of a combination of LABA + long-acting antimuscarinic antagonist (LAMA) + ICS, at up to maximally indicated doses for ≥ 3 months;
   b. If member is contraindicated to ICS, failure of dual inhaled therapy consisting of a combination of LABA + LAMA, at up to maximally indicated doses for ≥ 3 months;
6. For members with a eosinophilic phenotype with blood eosinophil count ≥ 300 cells/µL: Failure of a ≥ 4 consecutive month trial of Dupixent, used at up to maximally indicated doses, unless contraindicated or clinically significant adverse effects are experienced;^
   **Prior authorization may be required for Dupixent*
   ^For Illinois HIM requests, the step therapy requirements above do not apply as of 1/1/2026 per IL HB 5395
7. Provider attestation that member is concomitantly receiving triple therapy maintenance (e.g., LABA + LAMA + ICS) or double therapy maintenance (e.g., LABA + LAMA) if ICS is contraindicated;
8. Nucala is not prescribed concurrently with Cinqair, Dupixent, Fasenra, Xolair, or Tezspire;
9. Dose does not exceed 100 mg every 4 weeks.

Approval duration: 12 months

F. 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) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: HIM.PA.33 for health insurance marketplace; or
b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: HIM.PA.103 for health insurance marketplace; 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: HIM.PA.154 for health insurance marketplace.

II. Continued Therapy

A. Severe Asthma (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. Demonstrated adherence to asthma controller therapy (an ICS plus either an LABA or LTRA) as evidenced by proportion of days covered (PDC) of 0.8 in the last 6 months (i.e., member has received asthma controller therapy for at least 5 of the last 6 months);
3. Member is responding positively to therapy (examples may include but are not limited to: reduction in exacerbations or corticosteroid dose, improvement in forced expiratory volume over one second since baseline, reduction in the use of rescue therapy);
4. Nucala is not prescribed concurrently with Cinqair, Fasenra, Dupixent, Xolair, or Tezspire;
5. If request is for a dose increase, new dose does not exceed (a or b):
   a. Age 6 to 11 years: 40 mg every 4 weeks;
   b. Age ≥ 12 years: 100 mg every 4 weeks.

Approval duration: 12 months

B. Eosinophilic Granulomatosis with Polyangiitis (formerly Churg-Strauss) (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 (examples may include but are not limited to: reduction of relapses or reduction in glucocorticoid dose);
3. Nucala is not prescribed concurrently with Cinqair, Fasenra, Dupixent, Xolair, or Tezspire;

4. If request is for a dose increase, new dose does not exceed 300 mg every 4 weeks.

Approval duration: 12 months

C. Hypereosinophilic Syndrome (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 with reduction in flares from baseline or reduction in maintenance HES therapy dose from baseline (*see Appendix D*);
3. Nucala is prescribed concurrently with baseline HES therapy (e.g., oral corticosteroids, immunosuppressive therapy);
4. Nucala is not prescribed concurrently with Cinqair, Fasenra, Dupixent, Xolair, or Tezspire;
5. If request is for a dose increase, new dose does not exceed 300 mg every 4 weeks.

Approval duration: 12 months

D. Chronic Rhinosinusitis with Nasal Polyps (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. Demonstrated adherence to an intranasal corticosteroid, unless contraindicated or clinically significant adverse effects are experienced;
3. Member is responding positively to therapy (examples may include but are not limited to: reduced nasal polyp size, reduced need for systemic corticosteroids, improved sense of smell, improved quality of life);
4. Failure of a ≥ 4 consecutive month trial of Dupixent, used at up to maximally indicated doses, unless contraindicated or clinically significant adverse effects are experienced;^
   **Prior authorization may be required for Dupixent*
   ^For Illinois HIM requests, the step therapy requirements above do not apply as of 1/1/2026 per IL HB 5395
5. Nucala is not prescribed concurrently with Cinqair, Dupixent, Fasenra, Xolair, or Tezspire;
6. If request is for a dose increase, new dose does not exceed 100 mg every 4 weeks.

Approval duration: 12 months

E. Chronic Obstructive Pulmonary Disease (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. Nucala is not prescribed concurrently with Cinqair, Dupixent, Fasenra, Xolair, or Tezspire;
4. If request is for a dose increase, new dose does not exceed 100 mg every 4 weeks.

Approval duration: 12 months

F. 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) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: HIM.PA.33 for health insurance marketplace; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: HIM.PA.103 for health insurance marketplace; 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: HIM.PA.154 for health insurance marketplace.

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 – HIM.PA.154 for health insurance marketplace or evidence of coverage documents;

B. Acute bronchospasm or status asthmaticus.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

COPD: chronic obstructive pulmonary disease
CRSwNP: chronic rhinosinusitis with nasal polyps
EGPA: eosinophilic granulomatosis with polyangiitis
FDA: Food and Drug Administration
FEV_1: forced expiratory volume in 1 second
FIP1L1-PDGFRα: Fip1-like1-platelet-derived growth factor receptor alpha
FVC: forced vital capacity
GINA: Global Initiative for Asthma
HES: hypereosinophilic syndrome
ICS: inhaled corticosteroid
LABA: long-acting beta-agonist
LAMA: long-acting antimuscarinic antagonist
LTRA: leukotriene modifier
PDC: proportion of days covered

Appendix B: Therapeutic Alternatives
This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Asthma - ICS (medium – high dose)		
Qvar® (beclomethasone)	> 100 mcg/day 40 mcg, 80 mcg per actuation 1-4 actuations BID	4 actuations BID
budesonide (Pulmicort®)	> 200 mcg/day 90 mcg, 180 mcg per actuation 2-4 actuations BID	2 actuations BID
Alvesco® (ciclesonide)	> 80 mcg/day 80 mcg, 160 mcg per actuation 1-2 actuations BID	2 actuations BID
fluticasone propionate (Flovent®)	> 100 mcg/day 44-250 mcg per actuation 2-4 actuations BID	2 actuations BID
Arnuity Ellipta® (fluticasone furoate)	≥ 50 mcg/day 100 mcg, 200 mcg per actuation 1 actuation QD	1 actuation QD
Asmanex® (mometasone)	> 100 mcg/day HFA: 100 mcg, 200 mcg per actuation Twisthaler: 110 mcg, 220 mcg per actuation 1-2 actuations QD to BID	2 inhalations BID
Asthma - LABA		
Serevent® (salmeterol)	50 mcg per dose 1 inhalation BID	1 inhalation BID
Asthma - Combination Products (ICS + LABA)		
Dulera® (mometasone/ formoterol)	100/5 mcg, 200/5 mcg per actuation 2 actuations BID	4 actuations per day
Breo Ellipta® (fluticasone/ vilanterol)	100/25 mcg, 200/25 mcg per actuation 1 actuation QD	1 actuation QD
fluticasone/salmeterol (Advair®)	100/50 mcg, 250/50 mcg, 500/50 mcg per actuation 1 actuation BID	1 actuation BID
fluticasone/salmeterol (Airduo RespiClick®)	55/13 mcg, 113/14 mcg, 232/14 mcg per actuation 1 actuation BID	1 actuation BID

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
budesonide/formoterol (Symbicort®)	80 mcg/4.5 mcg; 160 mcg/4.5 mcg per actuation 1-2 actuations BID	2 actuations BID
Asthma - LTRA		
montelukast (Singulair®)	4 to 10 mg PO QD	10 mg per day
zafirlukast (Accolate®)	10 to 20 mg PO BID	40 mg per day
zileuton ER (Zyflo® CR)	1,200 mg PO BID	2,400 mg per day
Zyflo® (zileuton)	1,200 mg PO BID	2,400 mg per day
Asthma - Oral Glucocorticoids		
dexamethasone (Decadron)	0.75 to 9 mg/day PO in 2 to 4 divided doses	Varies
methylprednisolone (Medrol)	40 to 80 mg PO in 1 to 2 divided doses	Varies
prednisolone (Millipred®, Orapred ODT®)	40 to 80 mg PO in 1 to 2 divided doses	Varies
prednisone (Deltasone®)	40 to 80 mg PO in 1 to 2 divided doses	Varies
Asthma - Other		
Dupilumab (Dupixent®)	*Adults and adolescents (12 years and older)*: Initial dose of 400 mg SC followed by 200 mg SC every other week; or Initial dose of 600 mg SC followed by 300 mg SC every other week For patients requiring concomitant oral corticosteroids or with co-morbid moderate-to-severe atopic dermatitis for which Dupixent is indicated, start with an initial dose of 600 mg SC followed by 300 mg SC every other week *Adolescents 6-11 years of age*: • Body weight 15 to < 30 kg: Initial dose and subsequent dose of 300 mg every four weeks	See regimen

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
	• Body weight ≥ 30 kg: Initial dose and subsequent dose of 200 mg SC every other week For pediatric patients (6 to 11 years old) with asthma and co-morbid moderate-to-severe atopic dermatitis, follow the recommended adolescent atopic dermatitis dosing, which includes an initial loading dose	
Benralizumab (Fasenra®)	*Adult and adolescents (12 years and older):* • 30 mg SC every 4 weeks for the first 3 doses, followed by once every 8 weeks thereafter *Pediatric patients 6 - 11 years of age:* • < 35 kg: 10 mg SC every 4 weeks for the first 3 doses, followed by once every 8 weeks thereafter • ≥ 35 kg: 30 mg SC every 4 weeks for the first 3 doses, followed by once every 8 weeks thereafter	See regimen
EGPA		
methylprednisolone (Medrol)	6.0 mg/day to 0.8 mg/kg/day	Varies
prednisone (Deltasone)	7.5 mg/day to 1 mg/kg/day	Varies
cyclophosphamide*	1-2 mg/kg/day PO or 0.5-1 g/m^2/month IV	See regimen
azathioprine*	2-3 mg/kg PO QD	See regimen
methotrexate*	15 mg/week PO	25 mg/week
mycophenolate mofetil*	1.5-3 g/day PO	3 g/day
Benralizumab (Fasenra)	30 mg SC every 4 weeks	30 mg/4 weeks
HES		
oral corticosteroids:* prednisolone, prednisone	0.5 – 1 mg/kg/day	Varies
interferon alfa-2b (Intron-A®) *	1 – 6.25 million IU subcutaneously daily	20 million IU/m^2/day

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
imatinib (Gleevec®)	100 – 400 mg PO QD	400 mg/day
cyclosporine*	150 – 500 mg PO QD	Varies
azathioprine*	1 – 3 mg/kg PO QD	Varies
hydroxyurea*	0.5 – 3 gm PO QD with or without corticosteroid	80 mg/day
CRSwNP		
Intranasal corticosteroids		
beclomethasone (Beconase AQ®, Qnasl®)	1-2 sprays IN BID	2 sprays/nostril BID
budesonide (Rhinocort® Aqua, Rhinocort®)	128 mcg IN QD or 200 mcg IN BID	1-2 inhalations/nostril/ day
flunisolide	2 sprays IN BID	2 sprays/nostril TID
fluticasone propionate (Flonase®)	1-2 sprays IN BID	2 sprays/nostril BID
mometasone (Nasonex®)	2 sprays IN BID	2 sprays/nostril BID
Omnaris®, Zetonna® (ciclesonide)	Omnaris: 2 sprays IN QD Zetonna: 1 spray IN QD	Omnaris: 2 sprays/ nostril/day Zetonna: 2 sprays/ nostril/day
triamcinolone (Nasacort®)	2 sprays IN QD	2 sprays/ nostril/day
Xhance™ (fluticasone propionate)	1 to 2 sprays (93 mcg/spray) to nostril IN BID	744 mcg/day
Oral corticosteroids		
dexamethasone (Decadron®)	0.75 to 9 mg/day PO in 2 to 4 divided doses	Varies
methylprednisolone (Medrol®)	4 to 48 mg PO in 1 to 2 divided doses	Varies
prednisolone (Millipred®, Orapred ODT®)	5 to 60 mg PO in 1 to 2 divided doses	Varies
prednisone (Deltasone®)	5 to 60 mg PO in 1 to 2 divided doses	Varies
Other		
Dupilumab (Dupixent)	300 mg SC every other week	300 mg every other week
COPD		
ICS/LABA combinations		
fluticasone/salmeterol (Advair Diskus®)	Refer to prescribing information	Refer to prescribing information
Breo Ellipta® (fluticasone/vilanterol)		
budesonide/formoterol (Symbicort®)		

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Dulera®* (mometasone/formoterol)	Doses of 10 mcg formoterol/400 mcg mometasone and 10 mcg formoterol/ 200 mcg mometasone, each inhaled BID, have been studied	The optimal dose has not been established
LABA/LAMA combinations		
Bevespi Aerosphere® (formoterol/glycopyrrolate)	Refer to prescribing information	Refer to prescribing information
Utibron Neohaler® (indacaterol/glycopyrrolate)		
Anoro Ellipta® (vilanterol/umeclidinium)		
Stiolto Respimat® (olodaterol/tiotropium)		
LAMAs		
Tudorza Pressair® (aclidinium bromide)	Refer to prescribing information	Refer to prescribing information
Seebri Neohlaer® (glycopyrrolate)		
Spiriva Respimat®/ HandiHaler® (tiotropium)		
Incruse Ellipta® (umeclidinium)		
LABAs		
Brovana® (arformoterol)	Refer to prescribing information	Refer to prescribing information
Arcapta Neohaler® (indacterol)		
Striverdi Respimat® (olodaterol)		
Serevent Diskus® (salmeterol)		
ICS/LABA/LAMA combinations		
Trelegy™ Ellipta® (fluticasone/umeclidinium/ vilanterol)	1 inhalation by mouth QD	1 inhalation/day
Other		
Dupilumab (Dupixent)	300 mg SC every other week	300 mg SC every other week

Therapeutic alternatives are listed as Brand name® (generic) when the drug is available by brand name only and generic (Brand name®) when the drug is available by both brand and generic.
**Off-label*

Appendix C: Contraindications/Boxed Warnings

- Contraindication(s): hypersensitivity
- Boxed warning(s): none reported

Appendix D: General Information

- Asthma:
  - The pivotal trials defined severe asthma as two or more exacerbations of asthma despite regular use of high-dose inhaled corticosteroids plus an additional controller with or without oral corticosteroids. Clinically significant exacerbation was defined as a worsening of asthma leading to the doubling (or more) of the existing maintenance dose of oral glucocorticoids for three or more days or hospital admission or an emergency department visit for asthma treatment.
  - The Global Initiative for Asthma (GINA) guidelines recommend Nucala be considered as adjunct therapy for patients 6 years of age and older with exacerbations or poor symptom control despite taking at least high dose ICS/LABA and who have eosinophilic biomarkers or need maintenance oral corticosteroids.
  - Patients could potentially meet asthma criteria for both Xolair and Nucala, though data is insufficient to support combination use of multiple asthma biologics. The combination has not been studied. Approximately 30% of patients in the MENSA study also were candidates for therapy with Xolair.
  - PDC is a measure of adherence. PDC is calculated as the sum of days covered in a time frame divided by the number of days in the time frame. To achieve a PDC of 0.8, a member must have received their asthma controller therapy for 144 days out of the last 180 days, or approximately 5 months of the last 6 months.
- EGPA:
  - Standard of care for EGPA includes oral glucocorticoids. Induction therapy of prednisone 1 mg/kg/day is recommended for 2-3 weeks followed by gradual tapering to the minimal effective dose. Patients with stable doses of prednisone ≤ 7.5 mg/day are considered to be in remission, as defined by the European League Against Rheumatism (EULAR) and in the pivotal trial. The EGPA Consensus Task Force recommends that patients who are unable to taper prednisone to < 7.5 mg/day after 3-4 months of therapy should be considered for additional immunosuppressant therapy.
- Lab results for blood eosinophil counts can be converted into cells/mcL using the following unit conversion calculator: https://nucalahcp.com/severe-eosinophilic-asthma/eosinophils-and-moa/eosinophil-unit-calculator/
- Flares defined as a worsening of HES related clinical symptoms (e.g., pain, pruritus, skin lesions, nasal congestion, polyposis, dysphagia, or fatigue). An increase in blood eosinophil count requiring an escalation in therapy or above the predefined threshold level. An increase in maintenance oral corticosteroid dose by greater than or equal to 10 mg for 5 days or increase in/addition of any cytotoxic and/or immunosuppressive HES therapy.

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Severe asthma	Age 6 to 11 years: 40 mg SC every 4 weeks Age ≥ 12 years: 100 mg SC every 4 weeks	100 mg every 4 weeks
EGPA, HES	300 mg SC every 4 weeks	300 mg every 4 weeks
CRSwNP, COPD	100 mg SC every 4 weeks	100 mg every 4 weeks

VI. Product Availability

- Single-dose vial: 100 mg of lyophilized powder for reconstitution
- Single-dose prefilled glass syringe with needle for injection: 100 mg/mL
- Single-dose prefilled autoinjector with needle for injection: 100 mg/mL
- Single-dose prefilled glass syringe with needle for injection: 40 mg/0.4 mL

VII. References

1. Nucala Prescribing Information. Philadelphia, PA: GlaxoSmithKline LLC; May 29, 2025. Available at: www.nucala.com. Accessed May 29, 2025.
2. Clinical Pharmacology [database online]. Philadelphia, PA: Elsevier. Updated periodically. Available at: http://www.clinicalkey.com/pharmacology. Accessed May 29, 2025.

Asthma

3. National Asthma Education and Prevention Program: Expert panel report III: Guidelines for the diagnosis and management of asthma. Bethesda, MD: National Heart, Lung, and Blood Institute, 2007. (NIH publication no. 08-4051). Available at http://www.nhlbi.nih.gov/health-pro/guidelines/current/asthma-guidelines. Accessed November 14, 2024.
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Coding Implications

Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

HCPCS Codes	Description
J2182	Injection, mepolizumab, 1 mg

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created: adapted from CP.PHAR.200 [per December SDC: for CRSwNP, changed intranasal corticosteroid redirection from double to single step; for asthma, changed requirement of two to one exacerbation, removed intubation option and added ER visit option despite adherent use of controller therapy; for HES, removed requirement of corticosteroid and changed requirement to "member has tried at least one other HES treatment for a minimum of 4 weeks (e.g., oral corticosteroid, hydroxyurea, cyclosporine, imatinib, interferon-alfa, *see Appendix B*)".]	12.02.24	02.25
RT4: added criteria for new FDA approved indication of COPD.	05.29.25	

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Per SDC: for COPD, revised blood eosinophil count requirement from "≥ 300 cells/µL" to "≥ 150 cells/µL at time of request or ≥ 300 cells/µL in the past 12 months".	07.01.25	
Revised initial approval durations from 6 to 12 months. Per SDC request, the following revisions we made: for asthma increased required exacerbations from 1 to 2 in the last 12 months, added redirection to Dupixent and Fasenra; for EGPA added redirection to Fasenra; for HES added redirection to corticosteroid and removed criteria requiring member has tried at least one other HES treatment for a minimum of 4 weeks; for COPD added redirection to Dupixent. Per SDC request, for CRSwNP increased required intranasal corticosteroids from 1 to 2 (one of which must be Xhance).	12.08.25	12.25

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.