

POLICY Document for NUCALA (mepolizumab)

The overall objective of this policy is to support the appropriate and cost-effective use of the medication, specific to use of preferred medication options, and overall, clinically appropriate use. This document provides specific information to both sections of the overall policy.

Section 1: Preferred Product

- Policy information specific to preferred medications

Section 2: Site of Care

- Policy information specific to site of care (outpatient, hospital outpatient, home infusion)

Section 3: Clinical Criteria

- Policy information specific to the clinical appropriateness for the medication

Section 1: Preferred Product

CAREFIRST: EXCEPTIONS CRITERIA ASTHMA

PREFERRED PRODUCTS: FASENRA, NUCALA, XOLAIR, TEZSPIRE

Client Requested: The intent of the criteria is to ensure that patients follow selection elements as established by CareFirst.

POLICY

This policy informs prescribers of preferred products and provides an exception process for targeted products through prior authorization.

I. PLAN DESIGN SUMMARY

This program applies to the asthma products specified in this policy. Coverage for targeted product is provided based on clinical circumstances that would exclude the use of the preferred products and may be based on previous use of a product. The coverage review process will ascertain situations where a clinical exception can be made. This program applies to all members requesting treatment with a targeted product.

Each referral is reviewed based on all utilization management (UM) programs implemented for the client.

Table. Asthma Products

	Product(s)
Preferred*	<ul style="list-style-type: none"> • Fasenra (benralizumab) • Nucala (mepolizumab) • Xolair (omalizumab) • Tezspire (benralizumab)
Targeted	<ul style="list-style-type: none"> • Cinqair (reslizumab)

*: Medications considered formulary or preferred on your plan may still require a clinical prior authorization review

CareFirst Specialty Exceptions Asthma Products C26694-A 11-2023.docx

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Nucala SGM 1655-A P2024_R.docx

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II. EXCEPTION CRITERIA

This program applies to members requesting treatment for an indication that is FDA-approved for the preferred products.

Coverage for the targeted product is provided when the following criteria is met:

- A. Member has a documented inadequate response, contraindication, or intolerable adverse event to all preferred products.

Section 2: Site of Care

Site of Care Criteria Nucala

Products Referenced by this Document

Drugs that are listed in the following table include both brand and generic and all dosage forms and strengths unless otherwise stated. Nucala (autoinjector and prefilled syringe) is not targeted in this policy.

Brand Name	Generic Name	Dosage Form
Nucala	mepolizumab	subcutaneous

Criteria for Approval for Administration in Outpatient Hospital Setting

This policy provides coverage for provider administered Nucala in an outpatient hospital setting for up to 45 days when a member is new to therapy or is reinitiating therapy after not being on therapy for at least 6 months.

This policy provides coverage for administration of Nucala in an outpatient hospital setting for a longer course of treatment when ANY of the following criteria are met:

The member has experienced an adverse reaction to the drug that did not respond to conventional interventions (e.g., acetaminophen, steroids, diphenhydramine, fluids or other pre-medications) or a severe adverse event (anaphylaxis, anaphylactoid reactions, myocardial infarction, thromboembolism, or seizures) during or immediately after administration.

The member is medically unstable (e.g., respiratory, cardiovascular, or renal conditions).



The member has significant behavioral issues and/or physical or cognitive impairment that would impact the safety of drug administration AND the patient does not have access to a caregiver. Alternative infusion sites (pharmacy, physician office, ambulatory care, etc.) are greater than 30 miles from the member's home.

The member is less than 14 years of age.

For situations where administration of Nucala does not meet the criteria for outpatient hospital administration, coverage for Nucala is provided when administered in alternative sites such as; physician office, home infusion or ambulatory care.

Required Documentation

The following information is necessary to initiate the site of care prior authorization review (where applicable):

Medical records supporting the member has experienced an adverse reaction that did not respond to conventional interventions or a severe adverse event during or immediately after administration

Medical records supporting the member is medically unstable

Medical records supporting the member has behavioral issues and/or physical or cognitive impairment and no access to a caregiver

Records supporting alternative infusion sites are greater than 30 miles from the member's home

Medical records supporting the member is new to therapy

Section 3: Clinical Criteria

Specialty Guideline Management Nucala

Products Referenced by this Document

Drugs that are listed in the following table include both brand and generic and all dosage forms and strengths unless otherwise stated. Over-the-counter (OTC) products are not included unless otherwise stated.

Brand Name	Generic Name
Nucala	mepolizumab

Indications

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

FDA-Approved Indications¹

- Nucala is indicated for add-on maintenance treatment of patients with severe asthma aged 6 years and older, and with an eosinophilic phenotype.

Limitations of Use:

Not for relief of acute bronchospasm or status asthmaticus

- Nucala is indicated for the treatment of adult patients with eosinophilic granulomatosis with polyangiitis (EGPA).
- Nucala is indicated for the 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.
- Nucala is indicated for add-on maintenance treatment of adult patients 18 years and older with chronic rhinosinusitis with nasal polyps (CRSwNP).

All other indications are considered experimental/investigational and not medically necessary.

Documentation

Submission of the following information is necessary to initiate the prior authorization review:

Asthma:

For initial requests:

- Member's chart notes or medical record showing pretreatment blood eosinophil count, dependance on systemic corticosteroids if applicable.
- Chart notes, medical record documentation, or claims history supporting previous medications tried including drug, dose, frequency, and duration.

For continuation requests:

- Chart notes or medical record documentation supporting improvement in asthma control.

EGPA:

For initial requests:

- Member's chart notes or medical record showing pretreatment blood eosinophil count.
- Chart notes, medical record documentation, or claims history supporting previous medications tried including drug, dose, frequency, and duration.

For continuation requests:

- Chart notes or medical record documentation supporting improvement in EGPA control.

HES:**For initial requests:**

- FIP1L1-PDGFR α fusion gene test results.
- Member's chart notes or medical record showing pretreatment blood eosinophil count.

For continuation requests:

- Chart notes or medical record documentation supporting improvement in HES control.

CRSwNP:**For initial requests:**

- Member's chart notes or medical record showing nasal endoscopy, anterior rhinoscopy, or computed tomography details (e.g., location, size), or Meltzer Clinical Score or endoscopic nasal polyps score (NPS) (where applicable).
- Chart notes, medical record documentation, or claims history supporting previous medications tried. If therapy is not advisable, documentation of clinical reason to avoid therapy.

For continuation requests:

- Chart notes or medical record documentation supporting positive clinical response.

Exclusions

Coverage will not be provided for treatment of HES for members with any of the following exclusions:

- HES secondary to a non-hematologic cause (e.g., drug hypersensitivity, parasitic helminth infection, [human immunodeficiency virus] HIV infection, non-hematologic malignancy).
- FIP1L1-PDGFR α kinase-positive HES.

Prescriber Specialties

This medication must be prescribed by or in consultation with one of the following:

- Asthma: allergist/immunologist or pulmonologist
- Chronic rhinosinusitis with nasal polyposis: allergist/immunologist or otolaryngologist

Coverage Criteria

Asthma^{1-8,17}

Authorization of 6 months may be granted for members 6 years of age or older who have previously received a biologic drug (e.g., Dupixent, Cinqair) indicated for asthma in the past year.

Authorization of 6 months may be granted for treatment of severe asthma when all of the following criteria are met:

- Member is 6 years of age or older.
- Member meets either of the following criteria:
 - Member has a baseline blood eosinophil count of at least 150 cells per microliter.
 - Member is dependent on systemic corticosteroids.
- Member has uncontrolled asthma as demonstrated by experiencing at least one of the following within the past year:
 - Two or more asthma exacerbations requiring oral or injectable corticosteroid treatment.
 - One or more asthma exacerbation resulting in hospitalization or emergency medical care visit.
 - Poor symptom control (frequent symptoms or reliever use, activity limited by asthma, night waking due to asthma).
- Member has inadequate asthma control despite current treatment with both of the following medications at optimized doses:
 - High-dose inhaled corticosteroid.
 - Additional controller (i.e., long-acting beta2-agonist, long-acting muscarinic antagonist, leukotriene modifier, or sustained-release theophylline).
- Member will continue to use maintenance asthma treatments (e.g., inhaled corticosteroid, additional controller) in combination with the requested medication.

Eosinophilic Granulomatosis with Polyangiitis (EGPA)^{1,9-11,18}

Authorization of 12 months may be granted for treatment of eosinophilic granulomatosis with polyangiitis when all of the following criteria are met:

- Member is 18 years of age or older.
- Member has a history or the presence of an eosinophil count of more than 1000 cells per microliter or a blood eosinophil level of greater than 10%.
- Member is currently taking oral corticosteroids, unless contraindicated or not tolerated.
- Member has at least two of the following disease characteristics of EGPA^{8,9}:
 - Biopsy showing histopathological evidence of eosinophilic vasculitis, perivascular eosinophilic infiltration, or eosinophil-rich granulomatous inflammation
 - Neuropathy, mono or poly (motor deficit or nerve conduction abnormality)

- Pulmonary infiltrates, non-fixed
 - Sino-nasal abnormality
 - Cardiomyopathy (established by echocardiography or magnetic resonance imaging)
 - Glomerulonephritis (hematuria, red cell casts, proteinuria)
 - Alveolar hemorrhage (by bronchoalveolar lavage)
 - Palpable purpura
 - Anti-neutrophil cytoplasmic anti-body (ANCA) positive (Myeloperoxidase or proteinase 3)
- Member has had at least one relapse (i.e., requiring increase in oral corticosteroids dose, initiation/increased dose of immunosuppressive therapy or hospitalization) within 2 years prior to starting treatment with the requested medication or has a refractory disease.

Hypereosinophilic Syndrome (HES)^{1,13,14}

Authorization of 12 months may be granted for treatment of HES when all of the following criteria are met:

- Member is 12 years of age or older.
- Member has a history or presence of a blood eosinophil count of at least 1000 cells per microliter.
- Member will not use the requested medication as monotherapy.
- Member has been on a stable dose of HES therapy (e.g., oral corticosteroid, immunosuppressive, and/or cytotoxic therapy).
- Member has had HES for at least 6 months.
- Member has experienced at least two HES flares within the past 12 months.

Chronic Rhinosinusitis with Nasal Polyps^{1,15,16,19}

Authorization of 6 months may be granted for adult members who have previously received a biologic drug (e.g., Dupixent, Xolair) indicated for CRSwNP in the past year.

Authorization of 6 months may be granted for treatment of chronic rhinosinusitis with nasal polyps when all of the following criteria are met:

- Member is 18 years of age or older.
- Member has bilateral nasal polyposis and chronic symptoms of sinusitis despite intranasal corticosteroid treatment for at least 2 months unless contraindicated or not tolerated.
- The member has CRSwNP despite one of the following:
 - Prior sino-nasal surgery.
 - Prior treatment with systemic corticosteroids within the last two years was ineffective, unless contraindicated or not tolerated.
- Member has one of the following:

- A bilateral nasal endoscopy, anterior rhinoscopy, or computed tomography (CT) showing polyps reaching below the lower border of the middle turbinate or beyond in each nostril.
- Meltzer Clinical Score of 2 or higher in both nostrils.
- A total endoscopic nasal polyp score (NPS) of at least 5 with a minimum score of 2 for each nostril.
- Member has symptoms of nasal blockage, congestion, or obstruction plus one of the following additional symptoms:
 - Rhinorrhea (anterior/posterior).
 - Reduction or loss of smell.
 - Facial pain or pressure.
- Member will continue to use a daily intranasal corticosteroid while being treated with the requested medication, unless contraindicated or not tolerated.

Continuation of Therapy

Asthma^{1-7,17}

Authorization of 12 months may be granted for continuation of treatment of severe asthma when all of the following criteria are met:

- Member is 6 years of age or older.
- Asthma control has improved on the requested medication as demonstrated by at least one of the following:
 - A reduction in the frequency and/or severity of symptoms and exacerbations.
 - A reduction in the daily maintenance oral corticosteroid dose.⁷
- Member will continue to use maintenance asthma treatments (e.g., inhaled corticosteroid, additional controller) in combination with the requested medication.

Eosinophilic Granulomatosis with Polyangiitis (EGPA)^{1,9-12,18}

Authorization of 12 months may be granted for continuation of treatment of eosinophilic granulomatosis with polyangiitis when all of the following criteria are met:

- Member is 18 years of age or older.
- Member has beneficial response to treatment with the requested medication as demonstrated by any of the following:
 - A reduction in the frequency of relapses.
 - A reduction or discontinuance of daily oral corticosteroid dose.
 - No active vasculitis.

Hypereosinophilic Syndrome (HES)¹

Authorization of 12 months may be granted for continuation of treatment of HES when all of the following criteria are met:

- Member is 12 years of age or older.
- Member has experienced a reduction in HES flares since starting treatment with the requested medication.
- Member will not use the requested medication as monotherapy.

Chronic Rhinosinusitis with Nasal Polyps^{1,15-16}

Authorization of 12 months may be granted for continuation of treatment of chronic rhinosinusitis with nasal polyposis when all of the following are met:

- Member is 18 years of age or older.
- Member has achieved or maintained a positive clinical response with the requested medication as evidenced by improvement in signs and symptoms of CRSwNP (e.g., improvement in nasal congestion, nasal polyp size, loss of smell, anterior or posterior rhinorrhea, sinonasal inflammation, hyposmia and/or facial pressure or pain or reduction in corticosteroid use).
- Member will continue to use a daily intranasal corticosteroid while being treated with the requested medication, unless contraindicated or not tolerated.

Other

For all indications: Member cannot use the requested medication concomitantly with any other biologic drug or targeted synthetic drug for the same indication.

Note: If the member is a current smoker or vaper, they should be counseled on the harmful effects of smoking and vaping on pulmonary conditions and available smoking and vaping cessation options.

REFERENCES:

SECTION 1

1. Cinqair [package insert]. West Chester, PA: Teva Respiratory, LLC; June 2020.
2. Fasenra [package insert]. Wilmington, DE: AstraZeneca Pharmaceuticals LP; February 2021.
3. Nucala [package insert]. Research Triangle Park, NC: GlaxoSmithKline; March 2023.
4. Xolair [package insert]. South San Francisco, CA: Genentech, Inc.; March 2023.
5. Tezspire [package insert]. Wilmington, DE; AstraZeneca; December 2021.

SECTION 2

1. Nucala [package insert]. Philadelphia, PA: GlaxoSmithKline; March 2023.

SECTION 3

1. Nucala [package insert]. Durham, NC: GlaxoSmithKline; March 2023.
2. Ortega HG, Liu MC, Pavord ID, et al. Mepolizumab treatment in patients with severe eosinophilic asthma. *N Engl J Med*. 2014;371(13):1198-1207.
3. Bel EH, Wenzel SE, Thompson PJ, et al. Oral glucocorticoid-sparing effect of mepolizumab in eosinophilic asthma. *N Engl J Med*. 2014;371(13):1189-1197.
4. National Institutes of Health. National Asthma Education and Prevention Program Expert Panel Report 3: Asthma Management Guidelines: Focused Updates 2020. Bethesda, MD: National Heart Lung and Blood Institute; December 2020. Available at: <https://www.nhlbi.nih.gov/sites/default/files/publications/AsthmaManagementGuidelinesReport-2-4-21.pdf>. Accessed March 12, 2024.
5. Global Initiative for Asthma (GINA). Global Strategy for Asthma Management and Prevention. 2023 update. Available at: https://ginasthma.org/wp-content/uploads/2023/07/GINA-Full-Report-23_07_06-WMS.pdf. Accessed March 12, 2024.
6. Kew KM, Karner C, Mindus SM. Combination formoterol and budesonide as maintenance and reliever therapy versus combination inhaler maintenance for chronic asthma in adults and children (review). *Cochrane Database Syst Rev*. 2013;12:CD009019.
7. American Academy of Allergy, Asthma & Immunology (AAAAI) 2020 Virtual Annual Meeting. Available at: <https://annualmeeting.aaaai.org/>. Accessed March 12, 2024.
8. Wechsler ME, Akuthota P, Jayne D, et al. Mepolizumab or placebo for eosinophilic granulomatosis with polyangiitis. *N Engl J Med*. 2017;18;376(20):1921-1932.
9. GlaxoSmithKline. A Study to Investigate Mepolizumab in the Treatment of Eosinophilic Granulomatosis With Polyangiitis. Available from <https://clinicaltrials.gov/ct2/show/record/NCT02020889>. NLM identifier: NCT02020889. Accessed March 14, 2024.
10. Groh M, Pagnoux C, Baldini C, et al. Eosinophilic granulomatosis with polyangiitis (Churg–Strauss) (EGPA) Consensus Task Force Recommendations for evaluation and management. *Eur J Intern Med*. 2015;26(7):545-553.
11. Yates M, Watts RA, Bajema M, et al. EULAR/ERA-EDTA recommendations for the management of ANCA-associated vasculitis. *Ann Rheum Dis*. 2016;75(9):1583-1594.
12. Shomali W, Gotlib J. World Health Organization-defined eosinophilic disorders: 2022 update on diagnosis, risk stratification, and management. *Am J Hematol*. 2022;97(1):129-148.
13. Butt NM, Lambert J, Ali S, et al. Guideline for the investigation and management of eosinophilia. *Br J Haematol*. 2017;176(4):553-572.
14. Han JK, Bachert C, Fokkens W, et al. Mepolizumab for chronic rhinosinusitis with nasal polyps (SYNAPSE): a randomised, double-blind, placebo-controlled, phase 3 trial. *Lancet Respir Med*. 2021;9(10):1141-1153.
15. Bachert C, Han JK, Wagenmann M, et al. EUFOREA expert board meeting on uncontrolled severe chronic rhinosinusitis with nasal polyps (CRSwNP) and biologics: Definitions and management. *J Allergy Clin Immunol*. 2021;147(1):29-36.
16. Cloutier MM, Dixon AE, Krishnan JA, et al. Managing asthma in adolescents and adults: 2020 asthma guideline update from the National Asthma Education and Prevention Program. *JAMA*. 2020;324(22):2301-2317.

17. American College of Rheumatology. 2021 American college of rheumatology/vasculitis foundation guideline for the management of antineutrophil cytoplasmic antibody-associated vasculitis. Arthritis & Rheumatology. <https://www.vasculitisfoundation.org/wp-content/uploads/2021/07/2021-ACR-VF-Guideline-for-Management-of-ANCA-Associated-Vasculitis.pdf>. Accessed March 14, 2024.
18. WJ Fokkens, VJ Lund, C Hopkins, et al. European Position Paper on Rhinosinusitis and Nasal Polyps 2020. Rhinology. 2020;58(Suppl S29):1-464.
19. Hopkins C. Chronic Rhinosinusitis with Nasal Polyps. N Engl J Med. 2019;381(1):55-63.