MEDICAL MUTUAL®

# Drug Policy

| | | |
|---|---|---|
| **Policy:** | **201601-MRx (10-23)** | **Initial Effective Date: 02/28/2016** |
| **Code(s):** | **HCPCS J2182** | **Annual Review Date: 11/21/2024** |
| **SUBJECT:** | **Nucala® (mepolizumab)** | **Last Revised Date: 11/21/2024** |

**Prior approval is required for some or all procedure codes listed in this Corporate Drug Policy.**

## OVERVIEW

Nucala, an interleukin (IL)-5 antagonist monoclonal antibody, is indicated for the following uses:[1]

- **Asthma**, as add-on maintenance treatment of patients ≥ 6 years of age with severe disease with an eosinophilic phenotype. Limitations of Use: Nucala is not indicated for the relief of acute bronchospasm or status asthmaticus.
- **Chronic rhinosinusitis with nasal polyps** (CRSwNP), as an add-on maintenance treatment in patients ≥ 18 years of age with an inadequate response to nasal corticosteroids.
- **Eosinophilic granulomatosis with polyangiitis** (EGPA) [formerly known as Churg-Strauss Syndrome] in adult patients.
- **Hypereosinophilic syndrome** (HES), in patients ≥ 12 years of age who have had HES for ≥ 6 months without an identifiable non-hematologic secondary cause.

## POLICY STATEMENT

This policy involves the use of Nucala. Prior authorization is recommended for pharmacy benefit coverage of Nucala. Approval is recommended for those who meet the conditions of coverage in the **Criteria and Initial/Extended Approval** for the diagnosis provided. **Conditions Not Recommended for Approval** are listed following the recommended authorization criteria. Requests for uses not listed in this policy will be reviewed for evidence of efficacy and for medical necessity on a case-by-case basis.

Because of the specialized skills required for evaluation and diagnosis of patients treated with Nucala as well as the monitoring required for adverse events and long-term efficacy, initial approval requires Nucala be prescribed by or in consultation with a physician who specializes in the condition being treated. All approvals for initial therapy are provided for the initial approval duration noted below; if reauthorization is allowed, a response to therapy is required for continuation of therapy unless otherwise noted below.

**Automation:** None.

## RECOMMENDED AUTHORIZATION CRITERIA

Coverage of Nucala is recommended in those who meet one of the following criteria:

### FDA-Approved Indications

1. **Asthma.** Approve Nucala for the duration noted if the patient meets ONE of the following (A or B):
   - **A)** Initial Therapy. Approve for 6 months if the patient meets ALL of the following (i, ii, iii, iv, and v):
     - **i.** Patient is ≥ 6 years of age; AND
     - **ii.** Patient has a blood eosinophil level ≥ 150 cells per microliter within the previous 6 weeks or within 6 weeks prior to treatment with Nucala or another monoclonal antibody therapy that may lower blood eosinophil levels; AND
       Note: Examples of monoclonal antibody therapies that may lower blood eosinophil levels include Nucala, Adbry (tralokinumab-ldrm subcutaneous injection), Cinqair (reslizumab intravenous infusion), Dupixent (dupilumab subcutaneous injection), Fasenra (benralizumab subcutaneous injection), Tezspire (tezepelumab-ekko subcutaneous injection), Xolair (omalizumab subcutaneous injection).
     - **iii.** Patient has received at least 3 consecutive months of combination therapy with BOTH of the following (a and b):
       - **a)** An inhaled corticosteroid; AND
       - **b)** At least one additional asthma controller or asthma maintenance medication; AND

       Note: Examples of additional asthma controller or asthma maintenance medications are inhaled long-acting beta$_2$-agonists, inhaled long-acting muscarinic antagonists, and monoclonal antibody therapies for asthma (e.g., Cinqair, Dupixent, Fasenra, Nucala, Tezspire, and Xolair). Use of a combination inhaler containing both an inhaled corticosteroid and additional asthma controller/maintenance medication(s) would fulfill the requirement for both criteria a and b.
     - **iv.** Patient has asthma that is uncontrolled or was uncontrolled at baseline as defined by ONE of the following (a, b, c, d, or e):
       Note: "Baseline" is defined as prior to receiving Nucala or another monoclonal antibody therapy for asthma. Examples of monoclonal antibody therapies for asthma include Nucala, Cinqair, Dupixent, Fasenra, Tezspire, and Xolair.
       - **a)** Patient experienced two or more asthma exacerbations requiring treatment with systemic corticosteroids in the previous year; OR
       - **b)** Patient experienced one or more asthma exacerbation(s) requiring a hospitalization, an emergency department visit, or an urgent care visit in the previous year; OR
       - **c)** Patient has a forced expiratory volume in 1 second ($FEV_1$) < 80% predicted; OR
       - **d)** Patient has an $FEV_1$/forced vital capacity (FVC) < 0.80; OR
       - **e)** Patient has asthma that worsens upon tapering of oral (systemic) corticosteroid therapy; AND
     - **v.** The medication is prescribed by or in consultation with an allergist, immunologist, or pulmonologist.
   - **B)** Patient is Currently Receiving Nucala. Approve for 1 year if the patient meets ALL of the following (i, ii, and iii):
     - **i.** Patient has already received at least 6 months of therapy with Nucala; AND
       Note: A patient who has received < 6 months of therapy or who is restarting therapy with Nucala should be considered under criterion 1A (Asthma, Initial Therapy).
     - **ii.** Patient continues to receive therapy with one inhaled corticosteroid or one inhaled corticosteroid-containing combination inhaler; AND
     - **iii.** Patient has responded to therapy as determined by the prescriber.
       Note: Examples of a response to Nucala therapy are decreased asthma exacerbations; decreased asthma symptoms; decreased hospitalizations, emergency department, urgent care, or medical clinic visits due to asthma; and decreased requirement for oral corticosteroid therapy.

2. **Chronic Rhinosinusitis with Nasal Polyps**. Approve Nucala for the duration noted if the patient meets ONE of the following (A or B):
   - **A)** Initial Therapy. Approve for 6 months if the patient meets ALL of the following (i, ii, iii, iv, v, and vi):
     - **i)** Patient is ≥ 18 years of age; AND
     - **ii)** Patient has chronic rhinosinusitis with nasal polyps as evidenced by direct examination, endoscopy, or sinus computed **tomography (**CT) scan; AND
     - **iii)** Patient has experienced two or more of the following symptoms for at least 12 weeks: nasal congestion, nasal obstruction, nasal discharge, and/or reduction/loss of smell; AND
     - **iv)** Patient meets BOTH of the following (a and b):
       - **a)** Patient has received at least 4 weeks of therapy with an intranasal corticosteroid; AND
       - **b)** Patient will continue to receive therapy with an intranasal corticosteroid concomitantly with Nucala; AND
     - **v)** Patient meets ONE of the following (a, b, or c):
       - **a)** Patient has received at least one course of treatment with a systemic corticosteroid for 5 days or more within the previous 2 years; OR
       - **b)** Patient has a contraindication to systemic corticosteroid therapy; OR
       - **c)** Patient has had prior surgery for nasal polyps; AND
     - **vi)** Nucala is prescribed by or in consultation with an allergist, immunologist, or an otolaryngologist (ear, nose and throat [ENT] physician specialist).
   - **B)** Patient is Currently Receiving Nucala. Approve for 1 year if the patient meets ALL of the following (i, ii, and iii):
     - **i)** Patient has already received at least 6 months of therapy with Nucala; AND
       Note: A patient who has received < 6 months of therapy or who is restarting therapy with Nucala should be considered under criterion 4A [Nasal Polyps, Initial Therapy]).
     - **ii)** Patient continues to receive therapy with an intranasal corticosteroid; AND
     - **iii)** Patient has responded to therapy as determined by the prescriber.
       Note: Examples of a response to Nucala therapy are reduced nasal polyp size, improved nasal congestion, reduced sinus opacification, decreased sino-nasal symptoms, improved sense of smell.

3. **Eosinophilic Granulomatosis with Polyangiitis (EGPA) [formerly known as Churg-Strauss Syndrome].** Approve Nucala for the duration noted if the patient meets ONE of the following (A or B):
   - **A)** Initial Therapy. Approve for 6 months if the patient meets ALL of the following (i, ii, iii, and iv):
     - **i.** Patient is ≥ 18 years of age; AND
     - **ii.** Patient has active, non-severe disease; AND
       Note: 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, mild inflammatory arthritis.
     - **iii.** Patient meets BOTH of the following (a and b):
       - **a)** Patient is currently receiving a systemic corticosteroid (e.g., prednisone) and has been on therapy for a minimum of 4 weeks; AND
       - **b)** Patient has/had a blood eosinophil level ≥ 150 cells per microliter within the previous 6 weeks or within 6 weeks prior to treatment with any monoclonal antibody therapy that may lower blood eosinophil levels; AND

Note: Examples of monoclonal antibody therapies that may lower blood eosinophil levels include Nucala, Adbry (tralokinumab-ldrm subcutaneous injection), Cinqair (reslizumab intravenous infusion), Dupixent (dupilumab subcutaneous injection), Fasenra (benralizumab subcutaneous injection), Tezspire (tezepelumab-ekko subcutaneous injection), and Xolair (omalizumab subcutaneous injection).

**iv.** The medication is prescribed by or in consultation with an allergist, immunologist, pulmonologist, or rheumatologist.

**B)** Patient is Currently Receiving Nucala. Approve for 1 year if the patient meets BOTH of the following (i and ii):

**i.** Patient has already received at least 6 months of therapy with Nucala; AND
Note: A patient who has received < 6 months of therapy or who is restarting therapy with Nucala should be considered under criterion 2A (Eosinophilic Granulomatosis with Polyangiitis, Initial Therapy).

**ii.** Patient has responded to therapy as determined by the prescriber.
Note: Examples of a response to Nucala therapy are reduced rate of relapse, corticosteroid dose reduction, and reduced eosinophil levels.

**4. Hypereosinophilic Syndrome.** Approve Nucala for the duration noted if the patient meets ONE of the following (A or B):

**A)** Initial Therapy. Approve for 8 months if the patient meets ALL of the following (i, ii, iii, iv, v, vi, and vii):

**i.** Patient is ≥ 12 years of age; AND;

**ii.** Patient has had hypereosinophilic syndrome for ≥ 6 months; AND

**iii.** Patient has FIP1L1-PDGFRα-negative disease; AND

**iv.** Patient does NOT have an identifiable non-hematologic secondary cause of hypereosinophilic syndrome according to the prescriber; AND
Note: Examples of secondary causes of hypereosinophilic syndrome include drug hypersensitivity, parasitic helminth infection, human immunodeficiency virus infection, non-hematologic malignancy.

**v.** Patient has/had a blood eosinophil level ≥ 1,000 cells per microliter prior to treatment with any monoclonal antibody therapy that may lower blood eosinophil levels; AND
Note: Examples of monoclonal antibody therapies that may lower blood eosinophil levels include Nucala, Adbry (tralokinumab-ldrm subcutaneous injection), Cinqair (reslizumab intravenous infusion), Dupixent (dupilumab subcutaneous injection), Fasenra (benralizumab subcutaneous injection), Tezspire (tezepelumab-ekko subcutaneous injection), and Xolair (omalizumab subcutaneous injection).

**vi.** Patient has tried at least one other treatment for hypereosinophilic syndrome for a minimum of 4 weeks; AND
Note: Example of treatments for hypereosinophilic syndrome include systemic corticosteroids, hydroxyurea, cyclosporine, imatinib, or pegylated-interferon.

**vii.** Nucala is prescribed by or in consultation with an allergist, immunologist, pulmonologist, or rheumatologist.

**B)** Patient is Currently Receiving Nucala. Approve for 1 year if the patient meets BOTH of the following (i and ii):

**i.** Patient has already received at least 8 months of therapy with Nucala; AND
Note: A patient who has received < 8 months of therapy or who is restarting therapy with Nucala should be considered under criterion 3A (Hypereosinophilic Syndrome, Initial Therapy).

**ii.** Patient has responded to therapy as determined by the prescriber.
Note: Examples of a response to Nucala therapy are decreased number of flares, improved fatigue, reduced corticosteroid requirements, and decreased eosinophil levels.

**CONDITIONS NOT RECOMMENDED FOR APPROVAL**
Coverage of Nucala is not recommended in the following situations:

1. **Atopic Dermatitis.** Nucala is not indicated for the treatment of atopic dermatitis.[1] In one small study, intravenous (IV) mepolizumab significantly reduced peripheral blood eosinophil counts in patients with moderate to severe atopic dermatitis.[19,20] However, mepolizumab IV therapy did not result in clinical success as assessed by Physician's Global Assessment of Improvement scores compared with placebo. Other clinical outcomes were also not significantly improved with mepolizumab IV. Another small study evaluated subcutaneous Nucala in patients with moderate to severe atopic dermatitis.[21] Following 16 weeks of therapy, Nucala did not demonstrate efficacy, with 11% (n = 2/11) of patients meeting the primary endpoint of treatment success with Nucala vs. 0 with placebo. Further research is warranted to determine if Nucala has a place in therapy in the treatment of these conditions.

2. **Chronic Obstructive Pulmonary Disease (COPD).** Nucala is not indicated for the treatment of COPD.[1] Two Phase III studies, METREX (n = 836) and METREO (n = 675) evaluated Nucala in patients with COPD who had a history of moderate or severe exacerbations despite treatment with inhaled triple therapy (inhaled corticosteroid/long-acting muscarinic antagonist/long-acting beta$_2$-agonist).[22] METREX included patients regardless of eosinophil counts, but did include a subgroup of patients who were considered to have an eosinophilic phenotype (eosinophil count ≥ 150 cells/microliter) [n = 462]. METREO only included patients with an eosinophilic phenotype (defined as an eosinophil count ≥ 150 cells/microliter at screening or ≥ 300 cells/microliter within the previous year). Overall, lower COPD exacerbation rates were observed with Nucala vs. placebo; however, none of these reductions were statistically significant in either the METREX overall modified intent to treat (mITT) population or the METREO mITT population (which included all eosinophilic phenotype patients). In the subgroup of patients in the METREX study with an eosinophilic phenotype, the COPD exacerbation rates were statistically lower with Nucala vs. placebo, as was the difference in the time to first exacerbation. In July 2018, the FDA's Pulmonary Allergy Drugs Advisory Committee voted against approval of Nucala as an add-on treatment to inhaled corticosteroid-based maintenance treatments to reduce flare-ups in patients with COPD.[23] The Committee had concerns about the defining criteria for the eosinophilic phenotype of COPD as well as the lack of data on patient asthma history. Subsequently, in September 2018, the FDA rejected the approval of Nucala for COPD citing the need for additional clinical data. Current COPD guidelines from the Global Initiative for Chronic Lung Disease (2024) note the mixed data with Nucala.[24] The guidelines state that further studies are needed to determine if Nucala may have a role in a highly selected subgroup of patients with eosinophilic COPD.

3. **Concurrent use of Nucala with another Monoclonal Antibody Therapy.** The efficacy and safety of Nucala used in combination with other monoclonal antibody therapies have not been established.
   Note: Monoclonal antibody therapies are Adbry® (tralokinumab-ldrm subcutaneous injection), Cinqair® (reslizumab intravenous injection), Dupixent® (dupilumab subcutaneous injection), Fasenra® (benralizumab subcutaneous injection), Teszpire® (tezepelumab-ekko subcutaneous injection), or Xolair® (omalizumab subcutaneous injection).

4. **Eosinophilic Esophagitis, Eosinophilic Gastroenteritis, or Eosinophilic Colitis.** Nucala is not indicated for the treatment of eosinophilic esophagitis, eosinophilic gastroenteritis or eosinophilic colitis.[1] A few small studies reported IV mepolizumab to be efficacious in these conditions.[25-27] Of note, Nucala is not approved for IV administration.[1] One randomized, double-blind trial (n = 66) evaluated the efficacy of Nucala in patients with EoE.[28] Following 3 months of

therapy, there was no statistically significant improvement in dysphagia symptoms with Nucala vs. placebo, as measured by the EoE Symptom Activity Index (EEsAI) [primary endpoint]. The EEsAI was also not significantly different between the two treatment groups at 6 months of treatment. However, significantly more patients achieved a histologic response (i.e., < 15 eosinophils/high-power field) with Nucala compared with placebo. Guidelines for the management of eosinophilic esophagitis from the American Gastroenterological Association (AGA) and the Joint Task Force on Allergy-Immunology Practice Parameters (2020) only recommend using anti-interleukin-5 therapies in the context of a clinical trial.[29] Further research is warranted to determine if Nucala has a place in therapy in the treatment of these conditions.

**5.** Coverage is not recommended for circumstances not listed in the Recommended Authorization Criteria. Criteria will be updated as new published data are available.

**Dosage/Administration** [1]

| Indication | Dose |
|---|---|
| Severe Asthma with Eosinophilic Phenotype | Pediatric Patients Aged 6 to 11 years (100 mg single-dose vial or 40 mg/0.4 mL single-dose prefilled syringe ONLY)**§**:<br>40 mg administered subcutaneously once every 4 weeks<br>Adults and Adolescents Aged 12 years and older:<br>100 mg administered subcutaneously once every 4 weeks |
| Eosinophilic Granulomatosis with Polyangiitis/Churg-Strauss Syndrome | 300 mg administered subcutaneously once every 4 weeks as 3 separate 100-mg injections. Administer each injection at least 2 inches apart. |
| Hypereosinophilic Syndrome (HES) | 300 mg administered subcutaneously once every 4 weeks as 3 separate 100-mg injections. Administer each injection at least 2 inches apart. |
| Chronic Rhinosinusitis with Nasal Polyps (CRSwNP) | 100 mg administered subcutaneously once every 4 weeks. |
| **§***The 40 mg/0.4mL prefilled syringe is ONLY for use in children 6 to 11 years of age and must be administered by a healthcare provider or patient caregiver.*<br>**Note: The 100 mg single-dose vial must be prepared and administered by a healthcare professional; the 100 mg auto-injector or prefilled syringe may be self-administered.* | |

**Dosing Limits**

**A. Quantity Limit (max daily dose) [NDC Unit]:**

- Nucala 100 mg/mL single-dose vial for injection: 3 vials every 28 days
- Nucala 100 mg/mL single-dose prefilled autoinjector or syringe for injection: 3 autoinjectors or syringes every 28 days

- Nucala 40 mg/0.4 mL single-dose prefilled syringe for injection: 1 syringe every 28 days

**B. Max Units (per dose and over time) [HCPCS Unit]:**

**Severe Asthma with Eosinophilic Phenotype**

- 100 billable units every 28 days

**EGPA**

- 300 billable units every 28 days

**Hypereosinophilic Syndrome**

- 300 billable units every 28 days

**CRSwNP**

- 100 billable units every 28 days

## Billing Code/Availability Information

HCPCS Code:

- J2182 - Injection, mepolizumab, 1 mg; 1 billable unit = 1 mg

NDC(s):

- Nucala 100 mg/mL lyophilized powder single-dose vial: 00173-0881-xx
- Nucala 100 mg/mL single-dose prefilled autoinjector or syringe (cartons of 1): 00173-0892-xx
- Nucala 40 mg/0.4 mL single-dose prefilled syringe (cartons of 1): 00173-0904-xx

## References

1. Nucala® subcutaneous injection [prescribing information]. Research Triangle Park, NC: GlaxoSmithKline; March 2023.
2. Pavord ID, Korn S, Howarth P, et al. Mepolizumab for severe eosinophilic asthma (DREAM): a multicentre, double-blind, placebo-controlled trial. *Lancet*. 2012;380:651-659.
3. Ortega HG, Liu MC, Pavord ID, et al. Mepolizumab treatment in patients with severe eosinophilic asthma. *N Engl J Med*. 2014;371:1198-1207.
4. 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.
5. Han JK, Bachert C, Fokkens W, et al. Mepolizumab for chronic rhinosinusitis with nasal polyps (SYNAPSE): a randomized, double-blind, placebo-controlled, phase 3 trial. *Lancet Respir Med*. 2021;9(10):1141-1153.
6. Wechsler ME, Akuthota P, Jayne D. Mepolizumab or placebo for eosinophilic granulomatosis with polyangiitis. *N Engl J Med*. 2017;376(20):1921-1932.
7. Roufosse F, Kahn JE, Rothenberg ME, et al. Efficacy and safety of mepolizumab in hypereosinophilic syndrome: a phase III, randomized, placebo-controlled trial. *J Allergy Clin Immunol*. 2020;146(6):1397-1405.
8. Global Initiative for Asthma. Global strategy for asthma management and prevention. Updated 2023. Available at: http://www.ginasthma.org. Accessed on: April 9, 2024.
9. Chung KF, Wenzel SE, Brozek JL, et al. International ERS/ATS guidelines on definition, evaluation and treatment of severe asthma. *Eur Respir J*. 2014;43:343-373.
10. Holguin F, Cardet JC, Chung KF, *et al*. Management of severe asthma: a European Respiratory Society/American Thoracic Society Guideline. *Eur Respir J*. 2020;55:1900588.
11. Rank MA, Chu DK, Bognanni A, et al. Joint Task Force on Practice Parameters GRADE guidelines for the medical management of chronic rhinosinusitis with nasal polyposis. *J Allergy Clin Immunol*. 2023;151(2):386-398.
12. Peters AT, Spector S, Hsu J, et al. Diagnosis and management of rhinosinusitis: a practice parameter update. *Ann Allergy Asthma Immunol*. 2014:347-385.

13. Dykewicz MS, Wallace DV, Baroody F, et al. Treatment of seasonal allergic rhinitis: an evidenced-based focused 2017 guideline update. *Ann Allergy Asthma Immunol.* 2017;119(6):489-511.
14. Joint Task Force on Practice Parameters: American Academy of Allergy, Asthma and Immunology and the American College of Allergy, Asthma and Immunology. Rhinitis 2020: a practice parameter update. *J Allergy Clin Immunol.* 2020;146:721-767.
15. Rosenfeld RM, Piccirillo JF, Chandrasekhar SS, et al. Clinical practice guideline (update): adult sinusitis. *Otolaryngol Head Neck Surg*. 2015;152(2S):S1-S39.
16. Chung SA, Langford CA, Maz M, et al. 2021 American College of Rheumatology/Vasculitis Foundation guideline for the management of antineutrophil cytoplasmic antibody-associated vasculitis. *Arthritis Rheumatol.* 2021;73(8):1088-1105).
17. Hellmich B, Sanchez-Alamo B, Schirmer JH, et al. EULAR recommendations for the management of ANCA-associated vasculitis: 2022 update. *Ann Rheum Dis*. 2024;83(1):30-47.
18. Shomali W, Gotlib J. World Health Organization and international consensus classification of eosinophilic disorders: 2024 update on diagnosis, risk stratification, and management. *Am J Hematol*. 2024;99(5):946-968.
19. Oldhoff JM, Darsow U, Werfel T, et al. Anti-IL-5 recombinant humanized monoclonal antibody (mepolizumab) for the treatment of atopic dermatitis. *Allergy*. 2005;60(5):693-696.
20. Oldhoff JM, Darsow U, Werfel T, et al. No effect of anti-interleukin-5 therapy (mepolizumab) on the atopy patch test in atopic dermatitis patients. *Int Arch Allergy Immunol*. 2006;141(3):290-294.
21. Kang EG, Narayana PK, Pouliguen IJ, et al. Efficacy and safety of mepolizumab administered subcutaneously for moderate to severe atopic dermatitis. *Allergy*. 2020;75(4):950-953.
22. Pavord ID, Chanez P, Criner GJ, et al. Mepolizumab for eosinophilic chronic obstructive pulmonary disease. *N Engl J Med*. 2017;377(17):1613-1629.
23. GSK reports on outcome of the FDA Advisory Committee on mepolizumab for the treatment of COPD patients on maximum inhaled therapy [press release]. London, UK: GlaxoSmithKline; July 25, 2018. Available at: https://www.gsk.com/en-gb/media/press-releases/gsk-reports-on-outcome-of-the-fda-advisory-committee-on-mepolizumab-for-the-treatment-of-copd-patients-on-maximum-inhaled-therapy/. Accessed on April 9, 2024.
24. Global Initiative for Chronic Obstructive Lung Disease. Global strategy for the diagnosis, management, and prevention of chronic obstructive pulmonary disease: 2024 report. Global Initiative for Chronic Obstructive Lung Disease. Available from: http://goldcopd.org/. Accessed on April 9, 2024.
25. Stein ML, Collins MH, Villanueva JM, et al. Anti-IL-5 (mepolizumab) therapy for eosinophilic esophagitis. *J Allergy Clin Immunol*. 2006;118(6):1312-1319.
26. Straumann A, Conus S, Grzonka P, et al. Anti-interleukin-5 antibody treatment (mepolizumab) in active eosinophilic esophagitis: a randomized, placebo-controlled, double-blind trial. *Gut.* 2010;59:21-30.
27. Assa'ad AH, Gupta SK, Collins MH, et al. An antibody against IL-5 reduces numbers of esophageal intraepithelial eosinophils in children with eosinophilic esophagitis. *Gastroenterology*. 2011;141(5):1593-1604.
28. Dellon ES, Peterson KA, Mitlyng BL, et al. Mepolizumab for treatment of adolescents and adults with eosinophilic oesophagitis: a multicenter, randomized, double-blind, placebo-controlled clinical trial. *Gut*. 2023;72(10):1828-1837.
29. Hirano I, Chan ES, Rank MA, et al. AGA Institute and Joint Task Force on Allergy-Immunology Practice Parameters Clinical Guidelines for the Management of Eosinophilic Esophagitis. *Gastroenterology*. 2020;158(6):1776-1786.

## Appendix 1 – Covered Diagnosis Codes

| ICD-10 | ICD-10 Description |
|---|---|
| D72.110 | Idiopathic hypereosinophilic syndrome [IHES] |
| D72.111 | Lymphocytic Variant Hypereosinophilic Syndrome [LHES] |
| D72.119 | Hypereosinophilic syndrome [HES], unspecified |
| J33.0 | Polyp of nasal cavity |
| J33.1 | Polypoid sinus degeneration |
| J33.8 | Other polyp of sinus |

| ICD-10 | ICD-10 Description |
|---|---|
| J33.9 | Nasal polyp, unspecified |
| J45.50 | Severe persistent asthma, uncomplicated |
| J82.81 | Eosinophilic pneumonia, NOS |
| J82.82 | Acute eosinophilic pneumonia |
| J82.83 | Eosinophilic asthma |
| J82.89 | Other pulmonary eosinophilia, not elsewhere classified |
| M30.1 | Polyarteritis with lung involvement [Churg-Strauss] |

**Appendix 2 – Centers for Medicare and Medicaid Services (CMS)**

The preceding information is intended for non-Medicare coverage determinations. Medicare coverage for outpatient (Part B) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals. In addition, National Coverage Determinations (NCDs) and/or Local Coverage Determinations (LCDs) may exist and compliance with these policies is required where applicable. Local Coverage Articles (LCAs) may also exist for claims payment purposes or to clarify benefit eligibility under Part B for drugs which may be self-administered. The following link may be used to search for NCD, LCD, or LCA documents: https://www.cms.gov/medicare-coverage-database/search.aspx. Additional indications, including any preceding information, may be applied at the discretion of the health plan.

Medicare Part B Covered Diagnosis Codes (applicable to existing NCD/LCD/LCA): N/A

| Medicare Part B Administrative Contractor (MAC) Jurisdictions | | |
|---|---|---|
| **Jurisdiction** | **Applicable State/US Territory** | **Contractor** |
| E (1) | CA, HI, NV, AS, GU, CNMI | Noridian Healthcare Solutions, LLC |
| F (2 & 3) | AK, WA, OR, ID, ND, SD, MT, WY, UT, | Noridian Healthcare Solutions, LLC |
| 5 | KS, NE, IA, MO | Wisconsin Physicians Service Insurance Corp (WPS) |
| 6 | MN, WI, IL | National Government Services, Inc. (NGS) |
| H (4 & 7) | LA, AR, MS, TX, OK, CO, NM | Novitas Solutions, Inc. |
| 8 | MI, IN | Wisconsin Physicians Service Insurance Corp (WPS) |
| N (9) | FL, PR, VI | First Coast Service Options, Inc. |
| J (10) | TN, GA, AL | Palmetto GBA |
| M (11) | NC, SC, WV, VA (excluding below) | Palmetto GBA |

| Medicare Part B Administrative Contractor (MAC) Jurisdictions | | |
|---|---|---|
| **Jurisdiction** | **Applicable State/US Territory** | **Contractor** |
| L (12) | DE, MD, PA, NJ, DC (includes Arlington & Fairfax counties and the city of Alexandria in | Novitas Solutions, Inc. |
| K (13 & 14) | NY, CT, MA, RI, VT, ME, NH | National Government Services, Inc. (NGS) |
| 15 | KY, OH | CGS Administrators, LLC |

**Documentation Requirements:**
The Company reserves the right to request additional documentation as part of its coverage determination process. The Company may deny reimbursement when it has determined that the drug provided or services performed were not medically necessary, investigational or experimental, not within the scope of benefits afforded to the member and/or a pattern of billing or other practice has been found to be either inappropriate or excessive. Additional documentation supporting medical necessity for the services provided must be made available upon request to the Company. Documentation requested may include patient records, test results and/or credentials of the provider ordering or performing a service. The Company also reserves the right to modify, revise, change, apply and interpret this policy at its sole discretion, and the exercise of this discretion shall be final and binding.

**FOR MEDICAL BENEFIT COVERAGE REQUESTS:**

**MMO Site of Care Medical Necessity Criteria:**

• Medications in this policy will be administered in a place of service that is a non-hospital facility based location (i.e., home infusion provider, provider's office, free-standing ambulatory infusion center) unless at least one of the following are met†:

1. Age less than 18 years*; or
2. Clinically unstable based upon documented medical history (e.g., patient is hemodynamically unstable); or
3. History of a severe adverse event from previous administration of the prescribed medication; or
4. Requested medication is being administered as follows:
   - part of a chemotherapy regimen (e.g., anti-neoplastic agent, colony stimulating factor, erythropoiesis-stimulating agent, anti-emetic) for treatment of cancer; or
   - administered with dialysis; or
5. Physical or cognitive impairment and caregiver is not available to assist with safe administration of prescribed medication in the home; or
6. Experiencing adverse events that are not managed by premedication or resources available at a non-hospital facility based location.

No initial doses are allowed in a hospital based outpatient facility without other above criteria being met.

* Effective 01/01/2019, age criterion applies to 18 years of older. Age at original effective date (03/01/2016) was 21 years or older.

†This criterion does not apply to Medicare or Medicare Advantage members.

**Edits and Denials:**

**Prior approval:** Prior approval is required for Nucala **(HCPCS Code J2182)**. Requests for prior approval will be authorized by a nurse reviewer if submitted documentation meets criteria outlined within the Corporate Medical Policy.

Requests for prior approval will be forwarded to a qualified physician reviewer if submitted documentation does not meet criteria outlined within Corporate Medical Policy.

**TOPPS:** Claims received with **HCPCS Code J2182** will pend with **Remark Code PRR** and will be adjudicated in accordance with the Corporate Medical Policy.

**Liability:** A participating provider will be required to write off charges denied as not medically necessary.