EVH Clinical Guideline 5050.CC for Nucala (mepolizumab)

Guideline Number: EVH_CG_5050.CC	**Applicable Codes**	
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Original Date: March 2022	**Last Revised Date:** October 2025	**Implementation Date:** December 2025

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STATEMENT

General Information

- *It is the policy of the Health Plan to maintain a prior authorization process that promotes appropriate utilization of specific drugs with potential for misuse or limited indications. This process involves a review using Food and Drug Administration (FDA) criteria to make a determination of Medical Necessity, and approval by the Medical Policy Committee.*
- *If the established criteria are not met, the request is referred to a Medical Director for review, if required for the plan and level of request.*

Purpose

The purpose of this guideline is to define the prior authorization process for Nucala (mepolizumab).

Scope

This guideline applies to all practitioners who are involved in providing the requested drug. This guideline is specific to the Health Plan's medical benefit.

INITIAL REVIEW CRITERIA

The request must meet all of the criteria listed under the diagnosis-specific sections below.

Asthma

- Must be prescribed by or in consultation with an allergist, immunologist, or pulmonologist
- Must be 6 years or older
- Must have chart documentation supporting a diagnosis of severe persistent asthma, with the member meeting ONE of the following:
  - Baseline blood eosinophil count of ≥150 cells/mL
  - Member is dependent on systemic corticosteroids
- Dose should not exceed 100mg every 4 weeks
- Must have asthma symptoms that have not been adequately controlled on an optimized medication regimen, defined by **ONE** of the following:
  - Hospitalization or emergency visit for asthma in the past year
  - Requirement for systemic (oral, parenteral) corticosteroids to control exacerbations of asthma on TWO occurrences in the past year
  - On daily corticosteroid with inability to taper off

- Must have tried a high dose inhaled corticosteroid (see **Table 1 in Appendix** for ICS dosing guide) in combination with **ONE** of the following:
  - Inhaled long-acting beta agonist
  - Inhaled long-acting muscarinic antagonist
  - Leukotriene receptor antagonist
  - Theophylline
- Must have documentation or attestation from the provider of the following:
  - Will not be used with another biologic or targeted synthetic drug for asthma, such as Xolair (omalizumab) or Cinqair (reslizumab)
  - The member will continue to use maintenance asthma treatments (e.g., inhaled corticosteroid, additional controller) in combination with the requested medication

Chronic Rhinosinusitis with Nasal Polyps (CRSwNP)

- Must be 18 years or older
- Must be prescribed by an allergist, immunologist, or otolaryngologist (ENT)
- Must have a diagnosis of bilateral nasal polyps with documentation of at least ONE of the following:
  - 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
  - Total endoscopic nasal polyp score (NPS) of at least 5 with a minimum score of 2 for each nostril
- Must have documentation showing symptoms of nasal blockage, congestion, or obstruction plus ONE additional symptom below:
  - Rhinorrhea (anterior/posterior)
  - Reduction or loss of smell
  - Facial pain or pressure
- Dose should not exceed 100mg every 4 weeks
- Must have documentation of an adequate trial of nasal corticosteroids for at least TWO months with an inadequate response or significant side effects/toxicity or have a contraindication to these therapies
- Must have documentation of 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

- Must have documentation or attestation from the provider of the following:
  - That the requested medication will not be used with another biologic or targeted synthetic drug for CRSwNP, such as Xolair (omalizumab)
  - That the member will continue to use a daily intranasal corticosteroid while being treated with the requested medication, unless contraindicated or not tolerated

Chronic Obstructive Pulmonary Disease (COPD)

- Must have a diagnosis of COPD with moderate to severe airflow limitation, defined as both the following:
  - Post-bronchodilator forced expiratory volume in one second (FEV_1)/forced vital capacity (FVC) ratio less than 0.7
  - Post-bronchodilator FEV_1 of 20-80% predicted
- Must have classic signs or symptoms of COPD (e.g., dyspnea, wheezing, chest tightness, fatigue, activity limitation, cough with or without sputum production, chronic bronchitis
- Must have ONE of the following eosinophil levels:
  - ≥150 cell/mcL right before initiating therapy with the requested medication **OR**
  - ≥300 cells/mcL in the previous 12 months
- Must have documentation that the member has inadequately controlled COPD as demonstrated by experiencing either of the following in the last year:
  - At least two moderate exacerbations resulting in treatment with systemic glucocorticoids, antibiotics, or both **OR**
  - One or more severe exacerbation(s) requiring hospitalization or an emergency medical care visit
- Must be currently receiving maintenance inhaled triple therapy (i.e., inhaled corticosteroid [ICS], long-acting muscarinic antagonist [LAMA], and long-acting beta2-agonist [LABA]), unless there is a contraindication to these therapies
- Must have documentation showing the member will continue to use maintenance COPD treatments (e.g., ICS with LAMA and LABA, LAMA and LABA) in combination with the requested medication
- Must be prescribed at a dose within the manufacturer's dosing guidelines (based on diagnosis, weight, etc.) listed in the FDA-approved labeling

Eosinophilic Granulomatosis with Polyangiitis (EGPA)

- Must be prescribed by or in consultation with an allergist, immunologist, pulmonologist, rheumatologist, or hematologist
- Must be 18 years of age or older
- Must have a diagnosis of eosinophilic granulomatosis with polyangiitis, with chart note

documentation showing the member has at least TWO of the following disease characteristics of EGPA:

- 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)

- Must have a current or historical eosinophil count of >1000 cells/mL OR a blood eosinophil level of >10%
- Dose should not exceed 300mg every 4 weeks
- Must be currently taking oral corticosteroids, unless contraindicated or not tolerated
- Must have 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)

- Must be prescribed by or in consultation with an appropriate specialist such as allergist, immunologist, hematologist, or another specialist with experience in the treatment of HES
- Must be 12 years of age or older
- Must have a diagnosis of HES for six months or longer
- Dose should not exceed 300mg every 4 weeks
- Must have a historical or current blood eosinophil count of ≥ 1,000 cells/mcL
- Must have had an adequate trial of HES therapy (e.g., oral corticosteroid, immunosuppressive, and/or cytotoxic therapy)
- Must have documentation or attestation from the provider of the following:
  - Member does not have either of the following:
    - HES secondary to a non-hematologic cause (e.g., drug hypersensitivity, parasitic helminth infection, [human immunodeficiency virus] HIV infection, non-

hematologic malignancy)
        - FIP1L1-PDGFRA kinase-positive HES
    - Member will not use the requested medication as monotherapy

REAUTHORIZATION CRITERIA

All prior authorization renewals are reviewed on an annual basis to determine the Medical Necessity for continuation of therapy. The request must meet all of the criteria listed under the diagnosis-specific sections below.

Asthma

- Must have chart note documentation showing the member's asthma control has improved, as evidenced by either:
    - Reduction in the frequency and/or severity of symptoms and exacerbations
    - Reduction in the daily maintenance oral corticosteroid dose
- Must be prescribed at a dose within the manufacturer's dosing guidelines (based on diagnosis, weight, etc.) listed in the FDA-approved labeling
- Must have documentation or attestation from the provider of the following:
    - That the member will continue to use maintenance asthma treatments (e.g., inhaled corticosteroid, additional controller) in combination with the requested medication
    - Will not be used with another biologic or targeted synthetic drug for asthma, such as Xolair (omalizumab) or Cinqair (reslizumab)

Chronic Rhinosinusitis with Nasal Polyps (CRSwNP)

- Must have chart note documentation showing a beneficial response to treatment, as evidenced by 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)
- Must be prescribed at a dose within the manufacturer's dosing guidelines (based on diagnosis, weight, etc.) listed in the FDA-approved labeling
- Must have documentation or attestation from the provider of the following:
    - That the member will continue to use a daily intranasal corticosteroid while being treated with the requested medication, unless contraindicated or not tolerated
    - Will not be used with another biologic or targeted synthetic drug for CRSwNP, such as Xolair (omalizumab)

Chronic Obstructive Pulmonary Disease (COPD)

- Mut have chart note documentation showing the member has achieved or maintained a positive clinical response as evidenced by improvement in signs and symptoms of COPD (e.g., decrease in exacerbations, improvement in prebronchodilator FEV_1) or stabilization of disease
- Must have documentation showing the member will continue to use maintenance COPD treatments (e.g., ICS with LAMA and LABA, LAMA and LABA) in combination with the requested medication
- Must be prescribed at a dose within the manufacturer's dosing guidelines (based on diagnosis, weight, etc.) listed in the FDA-approved labeling

Eosinophilic Granulomatosis with Polyangiitis (EGPA)

- Must have chart note documentation showing a beneficial response to treatment, as evidenced by either:
  - A reduction in the frequency of relapses
  - A reduction in the daily oral corticosteroid dose
  - No active vasculitis
- Must be prescribed at a dose within the manufacturer's dosing guidelines (based on diagnosis, weight, etc.) listed in the FDA-approved labeling

Hypereosinophilic Syndrome (HES)

- Must have chart note documentation showing a beneficial response to treatment, as evidenced by a reduction in HES flares since starting treatment
- Must be prescribed at a dose within the manufacturer's dosing guidelines (based on diagnosis, weight, etc.) listed in the FDA-approved labeling
- Must have documentation or attestation from the provider that the requested medication is not being used as monotherapy

APPROVAL DURATIONS

Initial Authorization	Up to 1 year
Reauthorization	Same as initial

APPENDIX

Table 1: High daily metered doses of inhaled corticosteroids – adapted from GINA 2025 guidelines

Inhaled Corticosteroid (ICS)	Total daily ICS high dose (mcg) – ages 6 to 11 years	Total daily ICS high dose (mcg) ages ≥12 years
Beclometasone diproprionate (pMDI, standard particle, HFA)	>400	>1000
Beclometasone diproprionate (DPI or pMDI, extrafine particle, HFA)	>200	>400
Budesonide (DPI, or pMDI, standard particle, HFA)	>400	>800
Budesonide (nebules)	>1000	N/A
Ciclesonide (pMDI, extrafine particle, HFA)	>160	>320
Fluticasone furoate (DPI)	N/A	200
Fluticasone propionate (DPI, or pMDI, standard particle, HFA)	>200	>500
Mometasone furoate (pMDI, standard particle, HFA)	200	>400

CODING AND STANDARDS

Codes

Code	Brand	Description
J2182	Nucala	Injection, mepolizumab, 1mg

Applicable Lines of Business

☐	CHIP (Children's Health Insurance Program)
☐	Commercial
☐	Exchange/Marketplace
☒	Medicaid
☐	Medicare Advantage

BACKGROUND

Nucala® (mepolizumab) is indicated for the following:

- Add-on maintenance treatment of patients with severe asthma aged 6 years and older, and with an eosinophilic phenotype
- Add-on maintenance treatment of adult patients with inadequately controlled chronic obstructive pulmonary disease (COPD) and an eosinophilic phenotype
- Add-on maintenance treatment of adult patients 18 years and older with chronic rhinosinusitis with nasal polyps (CRSwNP)
- Treatment of adults with eosinophilic granulomatosis with polyangiitis (EGPA)
- 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

Definitions

Severe Asthma – As defined by the European Respiratory Society (ERS)/American Thoracic Society (ATS), severe asthma is "asthma that requires treatment with high dose inhaled corticosteroids […] plus a second controller (and/or systemic corticosteroids) to prevent it from becoming 'uncontrolled' or which remains 'uncontrolled' despite this therapy".

POLICY HISTORY

Date	Summary
October 2025	• Added COPD indication
September 2024	• Updated criteria for all indications and added indication-specific

Date	Summary
	reauthorization criteria
April 2023	• Updated initial authorization duration to 1 year • Changed severe asthma prerequisite number to one required
March 2022	• New Guideline

LEGAL AND COMPLIANCE

Guideline Approval

Committee

Reviewed / Approved by Evolent Administrative Services Medical Policy Committee

Disclaimer

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