

Nucala® (mepolizumab) (Subcutaneous)

Effective Date: 01/01/2020

Review Date: 12/18/2019, 12/20/2019, 1/29/2020, 9/9/2020, 11/2/2020, 3/18/2021, 01/05/2022, 1/05/2023, 12/07/23, 01/10/2024, 04/24/2024, 09/17/2025

Scope: Medicaid, Commercial, Medicare

I. Length of Authorization

Coverage is provided for six months and is eligible for renewal for 12 months.

II. Dosing Limits

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

- 100 mg/mL single dose vial for injection: 3 vials every 28 days
- 100 mg/mL single dose prefilled autoinjector or syringe for injection: 3 autoinjectors or syringes every 28 days
- 40mg/0.4ml single-dose prefilled syringe for injection: 1 syringe every 28 days

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

Severe Asthma with an eosinophilic phenotype

- 100 billable units every 28 days

EGPA

- 300 billable units every 28 days

Hypereosinophilic Syndrome

- 300 billable units every 28 days

CRSwNP & COPD

- 100 billable units every 28 days

III. Initial Approval Criteria ¹

Coverage is provided in the following conditions:

Universal Criteria ¹

- Must not be used in combination with other anti-IgE, anti-IL4, anti-IL5, or IgG2 lambda monoclonal antibody agents (e.g., Dupixent, Fasenra, Nucala, Xolair, Tezspire); **AND**

Severe Asthma †^{1-3,7,10}

- Patient is at least 6 years of age; **AND**
- Patient must have severe* disease; **AND**
- Nucala is prescribed by, or in consultation with, a pulmonologist or allergist/immunologist; **AND**
- Patient must have asthma with an eosinophilic phenotype defined as blood eosinophils ≥ 300 cells/ μ L within previous 12 months or ≥ 150 cells/ μ L within 6 weeks of dosing OR the patient is dependent on systemic corticosteroids; **AND**
- Patient is adherent to current treatment with both of the following medications at optimized doses:
 - Medium to high-dose inhaled corticosteroids; **AND**
 - An additional controller medication (e.g., long-acting beta agonist, long-acting muscarinic antagonists, leukotriene modifier), unless contraindicated or not tolerated; **AND**
- Will not be used for treatment acute bronchospasm or status asthmaticus; **AND**
- Patient must have inadequate asthma control with two or more exacerbations in the previous year requiring additional medical treatment (e.g., daily oral corticosteroids for at least 3 days, emergency department or urgent care visits, or hospitalizations) in addition to the regular maintenance therapy defined above; **AND**
- Baseline measurement of at least one of the following for assessment of clinical status:
 - Use of systemic corticosteroids
 - Use of inhaled corticosteroids
 - Number of hospitalizations, ER visits, or unscheduled visits to healthcare provider due to condition
 - Forced expiratory volume in 1 second (FEV₁)

Eosinophilic Granulomatosis with Polyangiitis (EGPA)/Churg-Strauss Syndrome † Φ^{1,5,6}

- Patient is at least 18 years of age; **AND**
- Nucala is prescribed by, or in consultation with, a pulmonologist, rheumatologist or allergist/immunologist; **AND**
- Patient has a confirmed diagnosis of EGPA§ (aka Churg-Strauss Syndrome); **AND**
- Patient must have blood eosinophils ≥ 150 cells/ μ L within 6 weeks of dosing; **AND**
- Patient has been on stable doses of concomitant oral corticosteroid therapy for at least 4 weeks (i.e., prednisone or prednisolone at a dose of 7.5 mg/day); **AND**
- Physician has assessed baseline disease severity utilizing an objective measure/tool (e.g., Birmingham Vasculitis Activity Score [BVAS], history of asthma symptoms and/or exacerbations, duration of remission, or rate of relapses, etc.)

Hypereosinophilic Syndrome (HES) † Φ^{1,11}

- Patient is at least 12 years of age; **AND**

- Patient has been diagnosed with HES for at least 6 months prior to starting treatment; **AND**
- Patient does NOT have non-hematologic secondary HES (e.g., drug hypersensitivity, parasitic helminth infection, HIV infection, non-hematologic malignancy) or FIP1L1-PDGFR α kinase-positive HES; **AND**
- Patient has a history of 2 or more HES flares within the previous 12 months (e.g., documented HES-related worsening of clinical symptoms or blood eosinophil counts requiring an escalation in therapy); **AND**
- Patient must have blood eosinophils ≥ 1000 cells/ μ L within 4 weeks of dosing; **AND**
- Used in combination with stable doses of at least one other HES therapy (e.g., oral corticosteroids, immunosuppressive agents, cytotoxic therapy, etc.)

Chronic Rhinosinusitis with Nasal Polyps (CRSwNP) †^{1,15,16}

- Patient is at least 18 years of age; **AND**
- Patient has bilateral symptomatic sino-nasal polyposis with symptoms lasting at least 8 weeks; **AND**
- Patient has failed on at least 8 weeks of intranasal corticosteroid therapy; **AND**
- Patient has at least three (3) of the following indicators for biologic treatment:
 - Patient has evidence of type 2 inflammation (e.g., tissue eosinophils ≥ 10 /hpf, blood eosinophils ≥ 150 cells/ μ L, or total IgE ≥ 100 IU/mL)
 - Patient has required ≥ 2 courses of systemic corticosteroids per year or >3 months of low dose corticosteroids, unless contraindicated
 - Disease significantly impairs the patient's quality of life
 - Patient has experienced significant loss of smell
 - Patient has a comorbid diagnosis of asthma; **AND**
- Patient does not have any of the following:
 - Antrochoanal polyps
 - Nasal septal deviation that would occlude at least one nostril
 - Disease with lack of signs of type 2 inflammation
 - Cystic fibrosis
 - Mucocoeles; **AND**
- Other causes of nasal congestion/obstruction have been ruled out (e.g., acute sinusitis, nasal infection or upper respiratory infection, rhinitis medicamentosa, tumors, infections, granulomatosis, etc.); **AND**
- Physician has assessed baseline disease severity utilizing an objective measure/tool; **AND**
- Therapy will be used in combination with intranasal corticosteroids unless not able to tolerate or use is contraindicated

Chronic Obstructive Pulmonary Disease (COPD)

Authorization may be granted for treatment of COPD in patients when all of the following criteria are met:

- Patient is 18 years of age or older; **AND**
- Diagnosis has been confirmed by spirometry showing forced expiratory volume in one second (FEV₁)/forced vital capacity (FVC) less than 0.7 post-bronchodilation; **AND**
- Patient demonstrates classic signs or symptoms of COPD (e.g., dyspnea, wheezing, chest tightness, fatigue, activity limitation, cough with or without sputum production, chronic bronchitis); **AND**
- Patient has an absolute blood eosinophil count of at least 150 cells per microliter prior to initiating therapy with the requested medication; **AND**
- Patient 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 hospitalizations or an emergency medical care visit; **AND**
- Patient meets either of the following:
 - Patient is currently receiving maintenance inhaled triple therapy (i.e., inhaled corticosteroid [ICS], long-acting muscarinic antagonist [LAMA], and long-acting beta2-agonist [LABA]); **OR**
 - Patient is currently receiving a LAMA and LABA, and has a contraindication to ICS ; **AND**
- Patient will continue to use maintenance COPD treatments (e.g., ICS with LAMA and LABA, LAMA and LABA) in combination with the requested medication.

*Components of severity for classifying asthma as severe may include any of the following (not all):

- Symptoms throughout the day
- Nighttime awakenings, often 7x/week
- SABA use for symptom control occurs several times per day
- Extremely limited normal activities
- Lung function (percent predicted FEV₁) <60%
- Exacerbations requiring oral systemic corticosteroids are generally more frequent and intense relative to moderate asthma

§Eosinophilic Granulomatosis Polyangiitis (EGPA) defined as all of the following:

- History or presence of asthma
- Blood eosinophil level > 10% or an absolute eosinophil count >1000 cells/mm³
- Two or more of the following criteria:
 - Histopathologic evidence of eosinophilic vasculitis, perivascular eosinophilic infiltration or eosinophil rich granulomatous inflammation

- Neuropathy
- Pulmonary infiltrates
- Sinonasal abnormalities
- Cardiomyopathy
- Glomerulonephritis
- Alveolar hemorrhage
- Palpable purpura
- Antineutrophil Cytoplasmic Antibody (ANCA) positivity

† FDA-approved indication(s); Φ Orphan Drug

IV. **Renewal Criteria** ^{1-3,5-7,10,11}

- Patient continues to meet the universal and other indication-specific relevant criteria identified in section III;
AND
- Absence of unacceptable toxicity from the drug. Examples of unacceptable toxicity include the following: parasitic (helminth) infection, herpes zoster infection, severe hypersensitivity reactions (e.g., anaphylaxis, angioedema, bronchospasm, hypotension, urticaria, rash, etc.), etc.; **AND**

Severe Asthma

- Improvement in asthma symptoms or asthma exacerbations as evidenced by decrease in one or more of the following:
 - Use of systemic corticosteroids
 - Two-fold or greater decrease in inhaled corticosteroid use for at least 3 days
 - Hospitalizations
 - ER visits
 - Unscheduled visits to healthcare provider; **OR**
- Improvement from baseline in forced expiratory volume in 1 second (FEV₁)

Eosinophilic Granulomatosis with Polyangiitis/Churg-Strauss Syndrome

- Disease response as indicated by improvement in signs and symptoms compared to baseline as evidenced by one or more of the following:
 - Patient is in remission [defined as a Birmingham Vasculitis Activity Score (BVAS) score=0 and a prednisone/prednisolone daily dose of ≤ 7.5 mg]
 - Decrease in maintenance dose of systemic corticosteroids
 - Improvement in BVAS score compared to baseline
 - Improvement in asthma symptoms or asthma exacerbations
 - Improvement in duration of remission or decrease in the rate of relapses

Hypereosinophilic Syndrome (HES)

- Disease response as indicated by a decrease in HES flares from baseline (**Note:** *An HES flare is defined as worsening of clinical signs and symptoms of HES or increasing eosinophils (on at least 2 occasions), resulting in the need to increase oral corticosteroids or increase/add cytotoxic or immunosuppressive HES therapy*).

Chronic Rhinosinusitis with Nasal Polyps (CRSwNP) †^{1,15}

- Disease response as indicated by improvement in signs and symptoms compared to baseline in one or more of the following: nasal/obstruction symptoms, improvement of sinus opacifications as assessed by CT-scans and/or an improvement on a disease activity scoring tool [e.g., nasal polyposis score (NPS), nasal congestion (NC) symptom severity score, sino-nasal outcome test-22 (SNOT-22), etc.]; **OR**
- Patient had an improvement in at least one (1) of the following response criteria:
 - Reduction in nasal polyp size
 - Reduction in need for systemic corticosteroids
 - Improvement in quality of life
 - Improvement in sense of smell
 - Reduction of impact of comorbidities

Chronic Obstructive Pulmonary Disease (COPD)

- Patient is 18 years of age or older
- Patient 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 pre-bronchodilator FEV1) or stabilization of disease
- Patient will continue to use maintenance COPD treatments (e.g., ICS with LAMA and LABA, LAMA and LABA) in combination with the requested medication.

V. Dosage/Administration ¹

Indication	Dose
Severe Asthma with eosinophilic phenotype	<u>Pediatric Patients Aged 6 to 11 years (single dose vial only):</u> 40 mg administered subcutaneously once every 4 weeks <u>Adults and Adolescents Aged 12 years and older:</u> 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.
Chronic Obstructive Pulmonary Disease (COPD)	100 mg administered subcutaneously once every 4 weeks.
<i>**Note: Single dose vial must be prepared and administered by a healthcare professional, the auto-injector or prefilled syringe may be self-administered.</i>	

VI. Billing Code/Availability Information

HCPCS Code:

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

NDC:

- 100 mg/mL single dose vial: 00173-0881-xx
- 100 mg/mL single dose prefilled autoinjector or syringe (cartons of 1): 00173-0892-xx

VII. References

1. Nucala [package insert]. Philadelphia, PA; GlaxoSmithKline LLC; August 2025. Accessed September 2025.
2. National Asthma Education and Prevention Program (NAEPP). Guidelines for the diagnosis and management of asthma. Expert Panel Report 3. Bethesda, MD: National Institutes of Health (NIH), National Heart, Lung, and Blood Institute (NHLBI); August 2007.
3. Global Initiative for Asthma (GINA). Global Strategy for Asthma Management and Prevention. 2019 Update. Available from: <http://www.ginasthma.org>. Accessed September 2020.
4. Wechsler ME, Akuthota P, Jayne D, et al. Mepolizumab or Placebo for Eosinophilic Granulomatosis with Polyangiitis. N Engl J Med. 2017 May 18;376(20):1921-1932. doi: 10.1056/NEJMoa1702079.
5. Hellmich B, Flossmann O, Gross WL, et al. EULAR recommendations for conducting clinical studies and/or clinical trials in systemic vasculitis: focus on antineutrophil cytoplasm antibody-associated vasculitis. Ann Rheum Dis 2007; 66: 605-17.
6. Masi AT, Hunder GG, Lie JT, Michel BA, et al. The American College of Rheumatology 1990 criteria for the classification of Churg-Strauss syndrome (allergic granulomatosis and angiitis). Arthritis Rheum. 1990; 33(8):1094-100 (ISSN: 0004-3591).
7. 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.
8. Yates M, Watts RA, Bajema IM, et al. EULAR/ERA-EDTA recommendations for the management of ANCA-associated vasculitis. Ann Rheum Dis. 2016 Sep;75(9):1583-94. doi: 10.1136/annrheumdis-2016-209133.
9. Groh M, Panoux C, Baldini C, et al. Eosinophilic granulomatosis with polyangiitis (Churg–Strauss) (EGPA) Consensus Task Force recommendations for evaluation and management. European Journal of Internal Medicine 26 (2015) 545–553.

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 [https://doi.org/10.1183/13993003.00588-2019]
11. Roufosse F, Kahn JE, Rothenberg ME, et al. Efficacy and safety of mepolizumab in hypereosinophilic syndrome: a Phase III, randomized, placebo-controlled trial. Journal of Allergy and Clinical Immunology (2020), doi: https://doi.org/10.1016/j.jaci.2020.08.037.

Appendix 1 – Covered Diagnosis Codes

ICD-10	ICD-10 Description
D72.1	Eosinophilia
J45.50	Severe persistent asthma, uncomplicated
J45.51	Severe persistent asthma with (acute) exacerbation
J45.52	Severe persistent asthma with status asthmaticus
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]