MEDICATION POLICY

Generic Name: Mepolizumab

Therapeutic Class or Brand Name: Nucala®

Applicable Drugs (if Therapeutic Class)**:** N/A

Date of Origin: 2/5/16 **Date Last Reviewed/Revised:** 7/14/17

GPI Code: 4460405500

Prior Authorization Criteria (may be considered medically necessary when criteria I through V are met):

I. Documented diagnosis of severe eosinophilic asthma AND a documented blood eosinophilia count of one of the following A or B:
   A. At least 300 cells/mcL in the previous 12 months.
   B. At least 150 cells/mcL in the previous 6 weeks.

II. Documentation that patient has been on a minimum of a three-month trial of a high-dose inhaled corticosteroid used in combination with a long-acting inhaled beta-2 agonist AND both criteria A and B are met:
   A. Documentation that patient is compliant to therapy as evidenced by pharmacy claims review (patient must have 3 fills of each inhaler within the previous 90 days).
   B. Documentation that patient's asthma symptoms are poorly controlled despite therapy.

III. Documentation that environmental factors and comorbid conditions that worsen patient's asthma symptoms are being identified and resolved.

IV. Minimum age requirement: 12 years old.

V. Prescriber must be an allergist, immunologist, or pulmonologist.

Exclusion Criteria:

- Concurrent use with Cinqair® (reslizumab) or Xolair® (omalizumab).
- Treatment of other eosinophilic conditions.
- Treatment of acute bronchospasm or status asthmaticus.

Other Criteria:

- N/A

Disclaimer: Medication Policies are developed to help ensure safe, effective and appropriate use of selected medications. They offer a guide to coverage and are not intended to dictate to providers how to practice medicine. Refer to Plan for individual adoption of specific Medication Policies. Providers are expected to exercise their medical judgment in providing the most appropriate care for their patients.

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Quantity/Days Supply Restrictions:

- One 100 mg injection every 28 days.

Approval Length:

- **Authorization:** 6 months.
- **Re-Authorization:** An updated letter of medical necessity or progress notes showing current medical necessity criteria are met and that the medication is effective.

Appendix:

N/A

References:

1. https://www.gsksource.com/pharma/content/dam/GlaxoSmithKline/US/en/Prescribing_Information/Nucala/pdf/NUCALA-PI-PIL.PDF.
2. http://www.nhlbi.nih.gov/files/docs/guidelines/asthgdln.pdf.
3. Medi-Span.
4. http://blue.regence.com/trgmedpol/drugs/dru428.pdf.
5. https://unityhealth.com/practitioners/medication-prior-authorization?did=1223.

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Historical Tracking Of Changes Made To Policy	
7/14/2017	1. **Changed** "Concurrent use with Xolair® (omalizumab)" **to** "Concurrent use with Cinqair® (reslizumab) or Xolair® (omalizumab)" **under Exclusion Criteria**.

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