Nucala® (mepolizumab)

Last Review Date: January 12, 2018

Number: MG.MM.PH.38a

Medical Guideline Disclaimer

Property of EmblemHealth. All rights reserved. The treating physician or primary care provider must submit to EmblemHealth the clinical evidence that the patient meets the criteria for the treatment or surgical procedure. Without this documentation and information, EmblemHealth will not be able to properly review the request for prior authorization. The clinical review criteria expressed below reflects how EmblemHealth determines whether certain services or supplies are medically necessary. EmblemHealth established the clinical review criteria based upon a review of currently available clinical information (including clinical outcome studies in the peer-reviewed published medical literature, regulatory status of the technology, evidence-based guidelines of public health and health research agencies, evidence-based guidelines and positions of leading national health professional organizations, views of physicians practicing in relevant clinical areas, and other relevant factors). EmblemHealth expressly reserves the right to revise these conclusions as clinical information changes, and welcomes further relevant information. Each benefit program defines which services are covered. The conclusion that a particular service or supply is medically necessary does not constitute a representation or warranty that this service or supply is covered and/or paid for by EmblemHealth, as some programs exclude coverage for services or supplies that EmblemHealth considers medically necessary. If there is a discrepancy between this guideline and a member’s benefits program, the benefits program will govern. In addition, coverage may be mandated by applicable legal requirements of a state, the Federal Government or the Centers for Medicare & Medicaid Services (CMS) for Medicare and Medicaid members. All coding and web site links are accurate at time of publication. EmblemHealth Services Company LLC, (“EmblemHealth”) has adopted the herein policy in providing management, administrative and other services to HIP Health Plan of New York, HIP Insurance Company of New York, Group Health Incorporated and GHI HMO Select, related to health benefit plans offered by these entities. All of the aforementioned entities are affiliated companies under common control of EmblemHealth Inc.

Definition

Nucala® is an interleukin-5 antagonist monoclonal antibody (IgG1 kappa) indicated for add-on maintenance treatment of patients with severe asthma aged 12 years and older, and with an eosinophilic phenotype. The drug is administered as a subcutaneous (SC) injection.

Related Medical Guidelines

Off-Label Use of FDA-Approved Drugs and Biologicals

Xolair® (omalizumab)

Dosing and Administration

Nucala Package Insert

Guideline

Criterion A or B must be met.

A. Nucala is considered medically necessary for members ≥ 12 years of age for the treatment of severe eosinophilic asthma when all of the following criteria are met:

1. Prescribed by an asthma specialist (e.g., allergist, immunologist, pulmonologist)
2. Pre-treatment eosinophilic asthma phenotype of either:
   a. ≥ 150 cells/μL at screening within 6 weeks prior to initiation of therapy
   b. ≥ 300 cells/μL within prior 12 months

Note: Alternate eosinophilia causes should be ruled out [i.e., hypereosinophilic syndromes, neoplastic disease and known or suspected parasitic infection]
3. Underlying conditions or triggers for asthma/pulmonary disease optimally managed

4. Clinical documentation of poor asthma control or recurrent exacerbations requiring additional treatment is received:
   a. Additional medical treatment may include any of the following: treatment with oral corticosteroids, emergency department visits, hospitalizations, or frequent office visits
   b. Poor asthma control may include but is not limited to clinical documentation of limitation in activities of daily living, nighttime awakening or dyspnea
   c. Recurrent exacerbation is defined as ≥ 2 acute exacerbations in a 12 month period

5. Symptoms inadequately controlled; either:
   a. 12 months of high-dose inhaled corticosteroid (ICS) given in combination with a minimum of 3 months of controller medication (either a long-acting beta2-agonist, or leukotriene receptor antagonist, or theophylline), unless member is intolerant of, or has a medical contraindication to these agents; or
   b. 6 months of ICS with daily oral glucocorticoids given in combination with a minimum of 3 months of controller medication (either a long-acting beta2-agonist, or leukotriene receptor antagonist, or theophylline), unless member is intolerant of, or has a medical contraindication to these agents

B. Nucala is considered medically necessary for members with eosinophilic granulomatosis with polyangiitis when member have all of the following criteria features:
   1. Asthma
   2. Eosinophilia (>10% on differential WBC count)
   3. Mononeuropathy
   4. Transient pulmonary infiltrates on chest X-rays
   5. Paranasal sinus abnormalities
   6. Biopsy containing a blood vessel with extravascular eosinophils
   7. Symptoms inadequately controlled by corticosteroids (prednisone or methylprednisone) AND immunosuppressive therapies (ex: azathioprine, mycophenolate mofetil, methotrexate, cyclophosphamide, or rituximab).

Authorization
   1. Initial authorization period of 6 months
   2. Renewal
      a. For treatment of severe eosinophilic asthma, renewal may be provided every 12 months for members not receiving an alternate IL-5 inhibitor and is predicated upon clinical documentation demonstrating a sustained positive therapeutic response, as evidenced by ≥ 1 of the following:
         i. Increase in Forced Expiratory Volume (FEV1) from pretreatment baseline
         ii. ICS dosing reduction
         iii. Reduction in oral corticosteroid use frequency
         iv. Reduction in asthma exacerbations (e.g., decreased frequency of emergency room/urgent care visits)
         v. Reduction in asthma symptoms (e.g., chest tightness, coughing, shortness of breath or nocturnal awakenings)
b. For treatment of eosinophilic granulomatosis with polyangiitis, renewal may be provided every 12 months.

Limitations/Exclusions
Nucala is considered investigational when used for all other conditions, including, but not limited to any:

1. Severe allergic asthma (without documentation of severe eosinophilia)
2. Use in combination with other anti-asthma monoclonal antibodies, including omalizumab (Xolair) or reslizumab (Cinqair) (for asthma or any indication)
3. Allergic bronchopulmonary aspergillosis (ABPA)
4. Atopic dermatitis
5. Chronic obstructive pulmonary disease (COPD)
6. Eosinophilic esophagitis (EE)
7. Hypereosinophilic syndrome (HES, “hyper-E”)
8. Nasal polyposis

Revision History
1/12/2018 — addition of covered use for eosinophilic granulomatosis with polyangiitis

Applicable Procedure Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>J2182</td>
<td>Injection, mepolizumab, 1 mg</td>
</tr>
</tbody>
</table>

Applicable Diagnosis Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>J45.50</td>
<td>Severe persistent asthma, uncomplicated</td>
</tr>
<tr>
<td>J45.51</td>
<td>Severe persistent asthma with (acute) exacerbation</td>
</tr>
<tr>
<td>J45.52</td>
<td>Severe persistent asthma with status asthmaticus</td>
</tr>
<tr>
<td>J82</td>
<td>Pulmonary eosinophilia, not elsewhere classified</td>
</tr>
<tr>
<td>M30.1</td>
<td>Polyarteritis with lung involvement [Churg-Strauss]</td>
</tr>
</tbody>
</table>

References

6. FDA advisory committee meeting briefing document: Nucala (mepolizumab) for treatment of patients with severe asthma with eosinophilic inflammation. GlaxoSmithKline, LLC.; 2015 May


11. Specialty matched clinical peer review.