Clinical Policy: Mepolizumab (Nucala)

Reference Number: CP.PHAR.200
Effective Date: 04.01.16
Last Review Date: 02.18
Line of Business: Commercial, Medicaid

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description
Mepolizumab (Nucala®) is a humanized IL-5 antagonist monoclonal antibody.

FDA Approved Indication(s)
Nucala is indicated for the add-on maintenance treatment of patients with severe asthma aged 12 years and older, and with an eosinophilic phenotype.

Limitation(s) of use: Nucala is not indicated for treatment of other eosinophilic conditions. Nucala is not indicated for the relief of acute bronchospasm or status asthmaticus.

Policy/Criteria
Provider must submit documentation (which may include office chart notes and lab results) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation® that Nucala is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Severe Asthma (must meet all)**:**

1. Diagnosis of asthma with absolute blood eosinophil count ≥150 cells/mcL within the past 3 months;
2. Prescribed by or in consultation with a pulmonologist or allergist;
3. Age ≥ 12 years;
4. Member has experienced ≥ 2 exacerbations with in the last 12 months, requiring any of the following despite adherent use of controller therapy (i.e., high dose inhaled corticosteroid (ICS) plus either a long acting beta-2 agonist (LABA) or leukotriene modifier (LTRA) if LABA contraindication/intolerance):
   a. Oral/systemic corticosteroid treatment (or increase in dose if already on oral corticosteroid);
   b. Urgent care visit or hospital admission;
   c. Intubation;
5. Nucala is prescribed concomitantly with an ICS plus either an LABA or LTRA;
6. Prescribed dose does not exceed 100 mg every 4 weeks.

Approval duration: 6 months

B. Other diagnoses/indications

1. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.CPA.09 for commercial and CP.PMN.53 for Medicaid.

II. Continued Therapy

A. Severe Asthma (must meet all)**:**

1. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
2. Demonstrated adherence to asthma controller therapy that includes an ICS plus either an LABA or LTRA;
3. Member is responding positively to therapy (e.g.: reduction in exacerbations or corticosteroid dose, improvement in forced expiratory volume$_1$ over one second) since baseline; reduction in the use of rescue therapy);
4. If request is for a dose increase, new dose does not exceed 100 mg every 4 weeks.

Approval duration:
Medicaid - 12 months
Commercial – 6 months or member's renewal period, whichever is longer

B. Other diagnoses/indications (must meet 1 or 2)**:**

1. Currently receiving medication via Centene benefit and documentation supports positive response to therapy.
   Approval duration: Duration of request or 6 months (whichever is less); or
2. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.CPA.09 for commercial and CP.PMN.53 for Medicaid.

III. Diagnoses/Indications for which coverage is NOT authorized:

A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies – CP.CPA.09 for commercial and CP.PMN.53 for Medicaid or evidence of coverage documents;

B. Acute bronchospasm or status asthmaticus.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key
ICS: inhaled corticosteroid
IL: interleukin
LABA: Long-acting beta-agonist
LTRA: leukotriene modifier

Appendix B: Therapeutic Alternatives
This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent and may require prior authorization.

Drug	Dosing Regimen	Dose/Limit/Maximum Dose
Inhaled corticosteroids		

Drug	Dosing Regimen	Dose/Limit/Maximum Dose
Beclomethasone (Qvar®)	40 mcg, 80 mcg/actuation 1-4 actuations BID	4 actuations BID
Budesonide (Pulmicort®)	200 mcg/actuation 1-2 actuations QD or BID	2 actuations BID
Alvesco® (ciclesonide)	80 mcg, 160 mcg per actuation 1-2 actuations BID	2 actuations BID
Aerospan® (flunisolide)	80 mcg per actuation 1-2 actuations BID	2 actuations BID
Flovent® (fluticasone propionate)	44-250 mcg per actuation 1-2 actuations BID	2 actuations BID
Arnuity Ellipta® (fluticasone furoate)	100 mcg, 200 mcg per actuation 1 actuation QD	1 actuation QD
Asmanex® (mometasone)	110 mcg, 220 mcg 1-2 inhalations QD to BID	2 inhalations BID
Long-acting beta-agonists		
Foradil® (formoterol)	12 mcg capsule for inhalation 1 capsule BID	24 mcg per day
Serevent® (salmeterol)	5 mcg per dose 1 inhalation BID	1 inhalation BID
Combination products		
Dulera® (mometasone/ formoterol)	100/5 mcg, 200/5 mcg per actuation 2 actuations BID	4 actuations per day
Breo Ellipta® (fluticasone/ vilanterol)	100/25 mcg, 200/25 mcg per actuation 1 actuation QD	1 actuation QD
Advair® (fluticasone/ salmeterol)	100/50 mcg, 250/50 mcg, 500/50 mcg per actuation 1 actuation BID	1 actuation BID
Symbicort® (budesonide/ formoterol)	80 mcg/4.5 mcg; 160 mcg/4.5 mcg per actuation 1-2 actuations BID	2 actuations BID
Antileukotriene agents		
Montelukast (Singulair®)	4 to 10 mg PO QD	10 mg per day

Drug	Dosing Regimen	Dose/Limit/Maximum Dose
Zafirlukast (Accolate®)	10 to 20 mg PO BID	40 mg per day
Zyflo® (zileuton)	1200 mg PO BID	2400 mg per day
Oral glucocorticoids		
Dexamethasone (Decadron)	0.75 to 9 mg/day PO in 2 to 4 divided doses	Varies
Methylprednisolone (Medrol)	40 to 80 mg PO in 1 to 2 divided doses	Varies

Therapeutic alternatives are listed as Brand name® (generic) when the drug is available by brand name only and generic (Brand name®) when the drug is available by both brand and generic.

Appendix C: General Information

- Nucala is not indicated for treatment of other eosinophilic conditions or relief of acute bronchospasm or status asthmaticus.
- The pivotal trials defined severe asthma as 2 or more exacerbations of asthma despite regular use of high-dose inhaled corticosteroids plus an additional controller with or without oral corticosteroids. Clinically significant exacerbation was defined as a worsening of asthma leading to the doubling (or more) of the existing maintenance dose of oral glucocorticoids for 3 or more days or hospital admission or an emergency department visit for asthma treatment.
- Controller medications are: inhaled glucocorticoids (Flovent, Pulmicort, Qvar, Asmanex), long-acting beta-agonists (LABAs) such as salmeterol, formoterol, or vilanterol, and antileukotriene agents (montelukast [Singulair®], zafirlukast [Accolate®] or Zyflo® [zileuton]). Theophylline is also a controller agent; however, it is not as efficacious as LABAs.
- Patients could potentially meet criteria for both Xolair and Nucala. The combination has not been studied. Approximately 30% of patients in the MENSA study also were candidates for therapy with Xolair.

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Severe asthma	100 mg SC every 4 weeks into the upper arm, thigh, or abdomen	100 mg every 4 weeks

VI. Product Availability

Vial: 100 mg of lyophilized powder in a single-dose vial for reconstitution

VII. References

1. Nucala Prescribing Information. Philadelphia, PA: GlaxoSmithKline LLC; February 2017. Available at: http://www.nucala.com. Accessed November 6, 2017.
2. National Asthma Education and Prevention Program: Expert panel report III: Guidelines for the diagnosis and management of asthma. Bethesda, MD: National Heart, Lung, and Blood Institute, 2007. (NIH publication no. 08-4051). Available at http://www.nhlbi.nih.gov/health-pro/guidelines/current/asthma-guidelines. Accessed November 2017.

3. Ortega HG, Liu MC, Pavord ID, et al. Mepolizumab treatment in patients with severe eosinophilic asthma. N Engl J Med 2014; 371:1198-207.
4. Bel EH, Wenzel SE, Thompson PH, et al. Oral glucocorticoid-sparing effect of mepolizumab in eosinophilic asthma. New Engl J Med 2014; 371:1189-97.
5. Pavord ID, Korn S, Howarth P et al. Mepolizumab for severe eosinophilic asthma (DREAM): a multicenter, double-blind, placebo-controlled trial (Abstract). Lancet 2012; 380(9842):651-59.
6. Clinical Pharmacology [database online]. Tampa, FL: Gold Standard, Inc.; 2017. Available at: http://www.clinicalpharmacology.com. Accessed November 2017.

Coding Implications
Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

HCPCS Codes	Description
J2182	Injection, mepolizumab, 1 mg

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy developed.	03.16	04.16
Controller trial requirements are edited in the initial and renewal criteria and a smoking cessation line item is added. Efficacy statement is added to renewal criteria. Approval durations changed to 6 and 12 months.	03.17	04.17
Changed temporary HCPCS code C9473 to permanent code J2182	08.17	02.18
1Q18 annual review - Combined Medicaid and Commercial policies. - Removed smoking cessation program requirements from existing Medicaid policy as this cannot be enforced. - Added “Acute bronchospasm or status asthmaticus” to section III as indications for which coverage is not authorized per PI. - References reviewed and updated.	11.06.17	02.18

Important Reminder
This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical

practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note:
For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.