Harvard Pilgrim Health Care | TUFTS Health Plan

Pharmacy Medical Necessity Guidelines:

# Nucala (mepolizumab) Pre-filled Autoinjector and Syringe

*Effective: September 1, 2026*

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| **Guideline Type** | ☒ Prior Authorization<br>☐ Non-Formulary<br>☐ Step-Therapy<br>☐ Administrative |

**Applies to:**

**Commercial Products**

☒ Harvard Pilgrim Health Care Commercial products; Fax: 617-673-0988

☒ Tufts Health Plan Commercial products; Fax: 617-673-0988

**Public Plans Products**

☒ Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product); Fax: 617-673-0988

**Note:** While you may not be the provider responsible for obtaining prior authorization, as a condition of payment you will need to ensure that prior authorization has been obtained.

## Overview

**Food and Drug Administration – Approved Indications**

**Nucala (mepolizumab) Pre-filled Autoinjector and Syringe** is an interleukin-5 antagonist monoclonal antibody (IgG1 kappa) indicated for:

- **Eosinophilic granulomatosis with polyangiitis**
  The treatment of adult patients with eosinophilic granulomatosis with polyangiitis
- **Hypereosinophilic Syndrome**
  The treatment of adult and pediatric patients aged 12 years and older with hypereosinophilic syndrome for at least 6 months without an identifiable non-hematologic secondary cause
- **Chronic rhinosinusitis with nasal polyps (CRSwNP)**
  Add-on maintenance treatment of CRSwNP in adult patients 18 years of age and older with Inadequate response to nasal corticosteroids
- **Chronic obstructive pulmonary disease (COPD)**
  As add-on maintenance treatment of adult patients with inadequately controlled chronic obstructive pulmonary disease (COPD) and an eosinophilic phenotype
- **Severe asthma**
  Add-on maintenance treatment of patients with severe asthma aged 6 years and older, and with an eosinophilic phenotype. Nucala is not indicated for the relief of acute bronchospasm or status asthmatics.

## Clinical Guideline Coverage Criteria

The plan may authorize coverage of Nucala pre-filled autoinjector and syringe for Members when **ALL** of the following criteria are met:

## Asthma

Initial Authorization Criteria

1. Submission of medical charts documenting a diagnosis of severe asthma with a pre-treatment blood eosinophil level greater than or equal to 150 cells per microliter

**AND**

2. Patient is six (6) years of age or older

**AND**

3. Prescribed by or in consultation with an allergist, immunologist, or pulmonologist

**AND**

4. Documentation of **one (1)** of the following within the previous 12 months:
   a. History of two (2) or more asthma exacerbations requiring systemic corticosteroids
   b. Prior asthma-related hospitalization

**AND**

5. Documentation of history of failure to a minimum three (3) month trial with a maximally tolerated inhaled corticosteroid plus at least one other asthma maintenance medication (e.g., long-acting inhaled beta2-agonist, long-acting muscarinic antagonist, leukotriene receptor antagonist), unless contraindicated

**AND**

6. Documentation the requested medication will be used as add-on maintenance therapy with a maximally tolerated inhaled corticosteroid plus at least one other asthma maintenance medication (e.g., long-acting inhaled beta2-agonist, long-acting muscarinic antagonist, leukotriene receptor antagonist), unless contraindicated

**AND**

7. Documentation the patient is not receiving the requested medication in combination with any of the following:
    a. Anti-interleukin-5 therapy (e.g., benralizumab, resilizumab)
    b. Anti-IgE therapy (e.g., omalizumab)
    c. Thymic stromal lymphopoietin (TSLP) inhibitor (e.g., tezepelumab)
    d. Anti-interleukin 4 therapy (e.g., dupilumab)

Reauthorization Criteria

1. Documented diagnosis of severe asthma of eosinophilic phenotype

**AND**

2. Patient is six (6) years of age or older

**AND**

3. Prescribed by or in consultation with an allergist, immunologist, or pulmonologist

**AND**

4. Documentation the patient has experienced a therapeutic response as defined by **one (1)** of the following:
    a. Increase in percent predicted Forced Expiratory Volume (FEV1) from pretreatment baseline
    b. Reduction in the dose of inhaled corticosteroids required to control asthma
    c. Reduction in asthma exacerbations (e.g., decreased frequency of use of unscheduled emergency department/urgent care visits)
    d. Reduction in asthma symptoms (e.g., chest tightness, coughing, shortness of breath, or nocturnal awakenings)
    e. Reduction in the use of oral corticosteroids to treat and/or prevent asthma exacerbations

**AND**

5. Documentation the requested medication will be used as add-on maintenance therapy with a maximally tolerated inhaled corticosteroid plus at least one other asthma medication (e.g., long-acting inhaled beta2-agonist, long-acting muscarinic antagonist, leukotriene receptor antagonist), unless contraindicated

**AND**

6. Documentation the patient is not receiving the requested medication in combination with any of the following:
    a. Anti-interleukin-5 therapy (e.g., benralizumab, resilizumab)
    b. Anti-IgE therapy (e.g., omalizumab)
    c. Thymic stromal lymphopoietin (TSLP) inhibitor (e.g., tezepelumab)
    d. Anti-interleukin 4 therapy (e.g., dupilumab)

## Chronic Rhinosinusitis with Nasal Polyps

Initial Authorization Criteria

1. Submission of medical charts documenting a diagnosis of chronic rhinosinusitis with nasal polyps

**AND**

2. Patient is 18 years of age or older

**AND**

3. Prescribed by or in consultation with an allergist, immunologist, or otolaryngologist

**AND**

4. Documentation of history of failure to a minimum eight (8) week trial of intranasal corticosteroids, unless contraindicated

**AND**

5. Documentation the requested medication will be used as add-on maintenance therapy with intranasal corticosteroids, unless contraindicated

**AND**

6. Documentation the patient is not receiving the requested medication in combination with any of the following:
    a. Anti-interleukin-5 therapy (e.g., benralizumab, resilizumab)
    b. Anti-IgE therapy (e.g., omalizumab)
    c. Thymic stromal lymphopoietin (TSLP) inhibitor (e.g., tezepelumab)

d. Anti-interleukin 4 therapy (e.g. dupilumab)

Reauthorization Criteria

1. Documented diagnosis of chronic rhinosinusitis with nasal polyps

**AND**

2. Patient is 18 years of age or older

**AND**

3. Prescribed by or in consultation with an allergist, immunologist, or otolaryngologist

**AND**

4. Documentation the requested medication will be used as an add-on maintenance therapy with intranasal corticosteroids, unless contraindicated

**AND**

5. Documentation the patient has experienced a therapeutic response as defined by at least **one (1)** of the following:
   a. Adequate sinus ventilation and drainage
   b. Control of mucosal inflammation and edema
   c. Reduction in exacerbation

**AND**

6. Documentation the patient is not receiving the requested medication in combination with any of the following:
   a. Anti-interleukin-5 therapy (e.g., benralizumab, resilizumab)
   b. Anti-IgE therapy (e.g., omalizumab)
   c. Thymic stromal lymphopoietin (TSLP) inhibitor (e.g., tezepelumab)
   d. Anti-interleukin 4 therapy (e.g. dupilumab)

## Eosinophilic granulomatosis with polyangiitis

Initial Authorization Criteria

1. Submission of medical charts documenting a diagnosis of eosinophilic granulomatosis with polyangiitis

**AND**

2. Patient is 18 years of age or older

**AND**

3. Prescribed by or in consultation with an allergist, immunologist, pulmonologist, or rheumatologist

**AND**

4. Documentation the patient has been stable on oral corticosteroid therapy for a minimum of four (4) weeks, unless contraindicated

**AND**

5. Documentation the patient's disease has relapsed or is refractory to standard of care therapy (i.e., corticosteroid treatment with or without immunosuppressive therapy)

**AND**

6. Documentation the patient is not receiving the requested medication in combination with any of the following:
   a. Anti-interleukin-5 therapy (e.g., benralizumab, resilizumab)
   b. Anti-IgE therapy (e.g., omalizumab)
   c. Thymic stromal lymphopoietin (TSLP) inhibitor (e.g., tezepelumab)
   d. Anti-interleukin 4 therapy (e.g. dupilumab)

Reauthorization Criteria

1. Documented diagnosis of eosinophilic granulomatosis with polyangiitis

**AND**

2. Patient is 18 years of age or older

**AND**

3. Prescribed by or in consultation with an allergist, immunologist, pulmonologist, or rheumatologist

**AND**

4. Documentation the patient has experienced a clinically significant improvement or stabilization in clinical signs and symptoms of disease as determined by the prescriber

**AND**

5. Documentation the patient is not receiving the requested medication in combination with any of the following:
   a. Anti-interleukin-5 therapy (e.g., benralizumab, resilizumab)
   b. Anti-IgE therapy (e.g., omalizumab)
   c. Thymic stromal lymphopoietin (TSLP) inhibitor (e.g., tezepelumab)

d. Anti-interleukin 4 therapy (e.g. dupilumab)

## Hypereosinophilic Syndrome

Initial Authorization Criteria

1. Submission of medical charts documenting a diagnosis of hypereosinophilic syndrome

**AND**

2. Documentation the patient has been diagnosed for at least six (6) months

3. Documentation that non-hematologic secondary causes (e.g., parasitic, allergic) have been ruled out

**AND**

4. Documentation the patient does not have FIP1-like1-platelet-derived growth factor receptor alpha (FIP1L1-PDGFRA) kinase positive hypereosinophilic syndrome

**AND**

5. Documentation of a pre-treatment blood eosinophil count greater than or equal to 1,000 cells per microliter

**AND**

6. Documentation of a history of two (2) or more hypereosinophilic syndrome flares within the previous 12 months (clinical manifestation or laboratory abnormality that resulted in an increase or addition of oral corticosteroids, or an increase or addition of new cytotoxic and/or immunosuppressive therapy)

**AND**

7. Patient is 12 years of age or older

**AND**

8. Prescribed by or in consultation with an allergist, immunologist, pulmonologist, dermatologist, or gastroenterologist

**AND**

9. Documentation of history of failure to a minimum four (4) week with one (1) of the following, unless contraindicated: Oral corticosteroid, oral immunosuppressant, or cytotoxic therapeutic agent

**AND**

10. Documentation the patient is not receiving the requested medication in combination with any of the following:
    a. Anti-interleukin-5 therapy (e.g., benralizumab, resilizumab)
    b. Anti-IgE therapy (e.g., omalizumab)
    c. Thymic stromal lymphopoietin (TSLP) inhibitor (e.g., tezepelumab)
    d. Anti-interleukin 4 therapy (e.g. dupilumab)

Reauthorization Criteria

1. Documented diagnosis of hypereosinophilic syndrome

**AND**

2. Patient is 12 years of age or older

**AND**

3. Prescribed by or in consultation with an allergist, immunologist, pulmonologist, dermatologist, or gastroenterologist

**AND**

4. Documentation the patient has experienced a clinically significant improvement or stabilization in clinical signs and symptoms of disease as determined by the prescriber

**AND**

5. Documentation the patient is not receiving the requested medication in combination with any of the following:
    a. Anti-interleukin-5 therapy (e.g., benralizumab, resilizumab)
    b. Anti-IgE therapy (e.g., omalizumab)
    c. Thymic stromal lymphopoietin (TSLP) inhibitor (e.g., tezepelumab)
    d. Anti-interleukin 4 therapy (e.g. dupilumab)

### Chronic Obstructive Pulmonary Disease

Initial Authorization Criteria

1. Submission of medical charts documenting a diagnosis of chronic obstructive pulmonary disease

**AND**

2. Documentation of presence of Type 2 inflammation evidence by blood eosinophils greater than or equal to 300 cells per microliter

**AND**

3. Documentation of moderate to severe airflow limitation as evidenced by **both** of the following:
    a. Post-bronchodilator forced expiratory volume in one second (FEV1)/ forced vital capacity (FVC) ratio less than 0.70

b. Post-bronchodilator forced expiratory volume in one second (FEV1) of 30% to 70%

**AND**

4. Documentation of **one (1)** of the following within the previous 12 months:
   a. At least two (2) moderate exacerbations defined as treatment with either systemic corticosteroids and/or antibiotics
   b. At least one (1) severe exacerbation defined as requiring hospitalization or observation for over 24 hours in an emergency department or urgent care facility

**AND**

5. Patient is 18 years of age or older

**AND**

6. Prescribed by or in consultation with a pulmonologist

**AND**

7. Documentation of history of failure with a maximally tolerated regimen on **one (1)** of the following, unless contraindicated:
   a. Triple therapy regimen with an inhaled corticosteroid, a long-acting muscarinic antagonist, and a long-acting beta agonist
   b. Dual therapy with a long-acting muscarinic antagonist and long-acting beta agonist due to contraindication to inhaled corticosteroids

**AND**

8. Documentation the requested medication will be used as add-on maintenance therapy in combination with **one (1)** of the following, unless contraindicated:
   a. Triple therapy regimen with an inhaled corticosteroid, a long-acting muscarinic antagonist, and a long-acting beta agonist
   b. Dual therapy with a long-acting muscarinic antagonist and long-acting beta agonist due to contraindication to inhaled corticosteroids

**AND**

9. Documentation the patient is not receiving the requested medication in combination with any of the following:
   a. Anti-interleukin-5 therapy (e.g., benralizumab, resilizumab)
   b. Anti-IgE therapy (e.g., omalizumab)
   c. Thymic stromal lymphopoietin (TSLP) inhibitor (e.g., tezepelumab)
   d. Anti-interleukin 4 therapy (e.g. dupilumab)

<u>Reauthorization Criteria</u>

1. Documented diagnosis of moderate to severe chronic obstructive pulmonary disease and an eosinophilic phenotype

**AND**

2. Patient is 18 years of age or older

**AND**

3. Prescribed by or in consultation with pulmonologist

**AND**

4. Documentation the patient has experienced a therapeutic response as defined by **one (1)** of the following:
   a. Reduction in the frequency of COPD exacerbations
   b. Increase in percent predicted FEV1 from pretreatment baseline
   c. Reduction in severity or frequency of COPD-related symptoms (e.g., dyspnea, wheezing, cough, sputum volume, decrease in sputum purulence)
   d. Reduction in oral corticosteroid requirements

**AND**

5. Documentation the requested medication will be used as add-on maintenance therapy in combination with **one (1)** of the following, unless contraindicated:
   a. Triple therapy regimen with an inhaled corticosteroid, a long-acting muscarinic antagonist, and a long-acting beta agonist
   b. Dual therapy with a long-acting muscarinic antagonist and long-acting beta agonist due to contraindication to inhaled corticosteroids

**AND**

6. Documentation the patient is not receiving the requested medication in combination with any of the following:
   a. Anti-interleukin-5 therapy (e.g., benralizumab, resilizumab)
   b. Anti-IgE therapy (e.g., omalizumab)
   c. Thymic stromal lymphopoietin (TSLP) inhibitor (e.g., tezepelumab)
   d. Anti-interleukin 4 therapy (e.g. dupilumab)

## Limitations

1. Initial approval of Nucala pre-filled autoinjector and syringe will be authorized for six (6) months. Reauthorization of Nucala pre-filled autoinjector and syringe will be provided in 12-month intervals.
2. Patients new to the plan stable on Nucala should be reviewed against Reauthorization Criteria. Members who have already initiated the requested medication using samples, free goods, similar offerings, or self-paying for the medication directly do not qualify for an established clinical response and should be reviewed against Initial Authorization Criteria.

## Codes

None

## References


1. Nucala (mepolizumab) [prescribing information]. Research Triangle Park, NC: GlaxoSmithKline; March 2023.
2. Bergmark RW, Pynnonen M. Diagnosis and First-Line Treatment of Chronic Sinusitis. JAMA 2017; 318:2344.
3. Rosenfeld RM, Piccirillo JF, Chandrasekhar SS, et al. Clinical practice guideline (update): adult sinusitis. Otolaryngol Head Neck Surg 2015; 152:S1
4. National Heart, Lung, and Blood Institute (NHLBI) & National Asthma Education and Prevention Program (NAEPP). 2020 Focused Updates to the Asthma Management Guidelines: A Report from the National Asthma Education and Prevention Program Coordinating Committee Expert Panel Working Group (EPR-4). 2020. Accessed April 17, 2024.
5. Global Initiative for Asthma (GINA). Global Strategy for Asthma Management and Prevention - GINA Report Updated 2023. 2023. Accessed April 17, 2024
6. Chung KF, Wenzel SE, Brozek JL, et al. International ERS/ATS guidelines on definition, evaluation and treatment of severe asthma. Eur Respir J. 2014 Feb; 43(2):343-373.
7. Chun EJ, Zhang HP, Lv Yan, et al. The Asthma Control Test and Asthma Control Questionnaire for assessing asthma control: systemic review and meta -analysis. J Allergy Clin Immunol. 2013 Mar;131(3):695-703.


## Approval And Revision History

September 13, 2022: Reviewed by the Pharmacy & Therapeutics Committee.

- May 9, 2023: No changes
- May 14, 2024: For chronic rhinosinusitis with nasal polyps updated diagnosis requirements to a documented diagnosis of chronic rhinosinusitis with nasal polyps and removed documentation the patient remains symptomatic despite treatment with an intranasal corticosteroid or contraindication to intranasal corticosteroids (eff 6/1/2024).
- May 13, 2025: No changes (eff 5/13/25)
- February 10, 2026: For EGPA, removed documentation the patient has at least two (2) disease characteristics of EGPA . Administrative update to remove CareLink from the Medical Necessity Guideline (eff 3/1/26).
- June 9, 2026: Effective July 1, 2026, added coverage criteria for the supplemental indication of chronic obstructive pulmonary disease (eff 7/1/26). Effective September 1, 2026: For EGPA added submission of medical charts confirming diagnosis (Initial), added minimum treatment duration of non-biologic prerequisites (Initial), added concurrent therapy language (Initial and Reauthorization), added submission of medical charts confirming broad reauthorization criteria (Reauthorization), and updated objective reauthorization criteria to broad reauthorization criteria (Reauthorization). For HES added submission of medical charts confirming diagnosis (Initial), added diagnosis for at least six (6) months (Initial), added documentation FIP1L1-PDGFR-negative (Initial), added history of two or more hypereosinophilic syndrome flares in previous 12 months (Initial), added minimum treatment duration of non-biologic prerequisites (Initial), added concurrent therapy language (Initial and Reauthorization), applied duration of approval rules (6 months initial, 12 month reauthorization), and added submission of medical charts confirming broad reauthorization criteria (Reauthorization). For Chronic Rhinosinusitis with Nasal Polyps added additional objective responses to therapy in objective reauthorization criteria (Reauthorization), separated confirmation of history of failure of inhaler prerequisites and requested use as add-on therapy to inhalers (Initial), added minimum treatment duration of non-biologic prerequisites (Initial), enhanced concurrent therapy language (Initial and Reauthorization), and submission of medical charts confirming objective reauthorization criteria (Reauthorization). For Chronic Obstructive Pulmonary Disorder added submission of medical charts confirming diagnosis (Initial), added documentation of moderate to severe airway limitation using two Spirometry requirements (Initial), separated confirmation of history of failure of inhaler prerequisites and requested use as add-on therapy to inhalers (Initial), added concurrent therapy language (Initial and Reauthorization), added submission of medical charts confirming objective reauthorization criteria (Reauthorization), and added additional objective responses to therapy in objective reauthorization criteria (Reauthorization). For Asthma added submission of medical charts confirming diagnosis (Initial), removed current treatment with an alternative respiratory biologic as confirmation of diagnosis (Initial), added severity requirements (history of exacerbations or hospitalization), separated confirmation of history of failure of inhaler prerequisites and requested use as add-on therapy to inhalers (Initial), added minimum treatment duration of non-biologic prerequisites (Initial), enhanced concurrent therapy language (Initial and Reauthorization), added confirmation treatment will be used as add-on therapy (Reauthorization), and added submission of medical charts confirming objective reauthorization criteria (Reauthorization). Added limitation statement that members who have already initiated the requested medication using samples, free goods, similar offerings, or

self-paying for the medication directly do not qualify for an established clinical response and should be reviewed against initial approval criteria. (eff 9/1/26).

- August 11, 2026: Removed submission of medical records requirements for response to therapy in Reauthorization Criteria. Modified criterion to Documentation the patient does not have FIP1-like1-platelet-derived growth factor receptor alpha (FIP1L1-PDGFRA) kinase positive hypereosinophilic syndrome in Initial Authorization Criteria for HES. Clarified what a qualifying HES flare is (eff 9/1/26).

## Background, Product and Disclaimer Information

Pharmacy Medical Necessity Guidelines have been developed for determining coverage for plan benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. The plan makes coverage decisions on a case-by-case basis considering the individual member's health care needs. Pharmacy Medical Necessity Guidelines are developed for selected therapeutic classes or drugs found to be safe, but proven to be effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in the service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. The plan revises and updates Pharmacy Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Pharmacy Medical Necessity Guideline and a self-insured Member’s benefit document, the provisions of the benefit document will govern.

Treating providers are solely responsible for the medical advice and treatment of members. The use of this policy is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management guidelines when applicable, and adherence to plan policies and procedures and claims editing logic.