Medical Necessity Guidelines

Medical Benefit Drugs

# Respiratory Interleukins: Cinqair® (reslizumab), Exdensur (depemokimab-ulaa), Fasenra® (benralizumab), Nucala® (mepolizumab)

*Effective: September 1, 2026*

| | |
|---|---|
| **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

☐ Tufts Health Together – MassHealth Accountable Care Partnership Plans; Fax 617-673-0939

☒ Tufts Health RITogether – A Rhode Island Medicaid Plan; Fax 617-673-0939

☐ Tufts Health One Care* – a Medicare-Medicaid Plan (a dual-eligible product); Fax 617-673-0956

*The MNG applies to Tufts Health One Care members unless a less restrictive LCD or NCD exists.

**Senior Products**

☐ Tufts Health Plan Senior Care Options (SCO), (a dual-eligible product); Fax 617-673-0956

☐ Tufts Medicare Preferred HMO, (a Medicare Advantage product); Fax 617-673-0956

☐ Tufts Medicare Preferred PPO, (a Medicare Advantage product); Fax 617-673-0956

**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 (FDA) Approved Indications:**

**Cinqair (reslizumab)** is an interleukin-5 antagonist monoclonal antibody (IgG4 kappa) indicated for:

- **Maintenance treatment of severe asthma**
  Add-on maintenance treatment of patients with severe asthma aged 18 years and older and with an eosinophilic phenotype. Cinqair (reslizumab) is not indicated for treatment of other eosinophilic conditions or for relief of acute bronchospasm or status asthmaticus.

**Exdensur (depemokimab-ulaa)** is an interleukin-5 antagonist monoclonal antibody (IgG1 kappa) indicated for:

- **Maintenance treatment of severe asthma**
  Add-on maintenance treatment of patients with severe asthma characterized by an eosinophilic phenotype in adults and pediatric patients aged 12 years and older. Exdensur (depemokimab-ulaa) is not indicated for the relief of acute bronchospasm or status asthmaticus.

**Fasenra (benralizumab)** is an interleukin-5 alpha directed cytolytic monoclonal antibody (IgG1, kappa) indicated for:

- **Maintenance treatment of severe asthma**
  Add-on maintenance treatment of patients with severe asthma aged 6 years and older and with an eosinophilic phenotype. Fasenra (benralizumab) is not indicated for treatment of other eosinophilic conditions or for relief of acute bronchospasm or status asthmaticus.
- **Eosinophilic granulomatosis with polyangiitis**
  The treatment of adult patients with eosinophilic granulomatosis with polyangiitis

**Nucala (mepolizumab)** 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
- **Maintenance treatment of 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) and an eosinophilic phenotype**
  As add-on maintenance treatment of adult patients with inadequately controlled chronic obstructive pulmonary disease (COPD) and an eosinophilic phenotype
- **Maintenance treatment of severe asthma**
  Add-on maintenance treatment of patients with severe asthma aged 6 years and older, and with an eosinophilic phenotype. Nucala (mepolizumab) is not indicated for the relief of acute bronchospasm or status asthmaticus

## Clinical Guideline Coverage Criteria

### Asthma

The plan may authorize coverage of a **Respiratory Interleukin** for Members when the following criteria are met:

Initial Authorization Criteria

1. Documented diagnosis of severe asthma of eosinophilic phenotype as determined by **one (1)** of the following:
    a. For Cinqair, an eosinophilic phenotype confirmed by a blood eosinophil level of at least 400 cells/mcL
    b. For Exdensur, an eosinophilic phenotype confirmed by a blood eosinophilic level of at least 150 cells/mcL
    c. For Fasenra, an eosinophilic phenotype confirmed by a blood eosinophil level of at least 150 cells/mcL
    d. For Nucala, one (1) of the following:
        i. An eosinophilic phenotype confirmed by a blood eosinophil level of at least 150 cells/mcL in the past six (6) weeks
        ii. An eosinophilic phenotype confirmed by a blood eosinophil level of at least 300 cells/mcL in the past 12 months
    e. Current treatment with an alternative biologic indicated for moderate to severe allergic or eosinophilic asthma
    f. Patient is dependent on systemic corticosteroids

**AND**

2. The patient's age is:
    a. 18 years of age or older for Cinqair
    b. 12 years of age or older for Exdensur
    c. 6 years of age or older for Fasenra
    d. 6 years of age or older for Nucala

**AND**

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

**AND**

4. Documentation the patient is currently maintained on 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)

**AND**

5. The patient will not be concurrently treated with an alternative biologic for asthma

**AND**

6. For Exdensur, documentation of inadequate response, adverse reaction, or contraindication to omalizumab and another biologic indicated for asthma (e.g., dupilumab, reslizumab, benralizumab, mepolizumab, tezepelumab-ekko)

Reauthorization Criteria

1. Documented diagnosis of severe asthma of eosinophilic phenotype

**AND**

2. The patient's age is:
    a. 18 years of age or older for Cinqair

b. 12 years of age or older for Exdensur
c. 6 years of age or older for Fasenra
d. 6 years of age or older for Nucala

**AND**

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

**AND**

4. Documentation that the Member has experienced a therapeutic response as defined by at least **one (1)** of the following:
    a. Increase in percent 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/hospitalizations)
    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. The patient will not be concurrently treated with an alternative biologic for asthma

**Chronic Rhinosinusitis with Nasal Polyps**

The plan may authorize coverage of **Nucala** for Members when **ALL** of the following criteria are met:

Initial Authorization Criteria

1. Documented diagnosis of chronic rhinosinusitis with nasal polyps as evidenced by **both** of the following:
    a. Symptoms of chronic rhinosinusitis for at least 12 weeks (e.g., decreased sense of smell; facial pressure, pain, fullness; mucopurulent drainage; mucosal inflammation; nasal obstruction )
    b. Presence of nasal polyps

**AND**

2. Patient is at least 18 years of age or older

**AND**

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

**AND**

4. Documentation of **one (1)** of the following:
    a. Patient will be concurrently treated with an intranasal corticosteroid
    b. Contraindication to intranasal corticosteroids

**AND**

5. The patient is not being concurrently treated with an alternative biologic for nasal polyps

Reauthorization Criteria

1. Documented diagnosis of chronic rhinosinusitis with nasal polyps

**AND**

2. Patient is at least 18 years of age or older

**AND**

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

**AND**

4. Documentation of **one (1)** of the following:
    a. Patient will be concurrently treated with an intranasal corticosteroid
    b. Contraindication to intranasal corticosteroids

**AND**

5. Documentation that the Member 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 exacerbations

**AND**

6. The patient will not be concurrently treated with an alternative biologic for nasal polyps

**Eosinophilic Granulomatosis with Polyangiitis**

The plan may authorize coverage of **Fasenra or Nucala** for Members when **ALL** of the following criteria are met:

Initial Authorization 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 of **one (1)** of the following:
    a. The patient is stable on corticosteroids
    b. Contraindication to corticosteroids

**AND**

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

Reauthorization Criteria

1. Documented diagnosis of eosinophilic granulomatosis with polyangiitis

**AND**

2. Patient is at least 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 therapeutic response as defined by at least **one (1)** of the following:
    a. A reduction in the frequency and/or severity of relapses
    b. A reduction or discontinuation of doses of corticosteroids
    c. Disease remission

**Hypereosinophilic Syndrome**

The plan may authorize coverage of **Nucala** for Members when **ALL** of the following criteria are met:

1. Documented diagnosis of hypereosinophilic syndrome

**AND**

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

**AND**

3. Patient is at least 12 years of age or older

**AND**

4. Documentation of a blood eosinophil count of at least 1,000 cells/mcL prior to the start of treatment

**AND**

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

**AND**

6. Documentation of **one (1)** of the following:
    a. Trial and failure with at least one (1) of the following: An oral corticosteroid, oral immunosuppressant, or cytotoxic therapeutic agent
    b. Contraindication to all of the following: Oral corticosteroids, oral immunosuppressants, and cytotoxic therapies

**Chronic obstructive pulmonary disease (COPD) and an eosinophilic phenotype**

The plan may authorize coverage of **Nucala** for Members when **ALL** of the following criteria are met:

Initial Authorization Criteria

1. Documented diagnosis of chronic obstructive pulmonary disease (COPD)

**AND**

2. All of the following:
    a. Post-bronchodilator forced expiratory volume (FEV1) / forced vital capacity (FVC) ratio less than 0.7
    b. Post-bronchodilator FEV1 % predicted greater than or equal to 30% and less than or equal to 70%

c. Patient has an eosinophilic phenotype defined by a baseline (pre-mepolizumab treatment) peripheral blood eosinophil level ≥ 300 cells/μL

**AND**

3. Patient is at least 18 years of age or older

**AND**

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

**AND**

5. Documented of **both (2)** of the following:
    a. Uncontrolled or inadequately controlled COPD
    b. Patient has experienced COPD exacerbations while receiving maintenance therapy consisting of either of the following:
        i. Tripple therapy with a long-acting muscarinic agonist (LAMA), long-acting beta agonist (LABA), and Inhaled corticosteroids (ICS)
        ii. Dual therapy with a long-acting muscarinic agonist (LAMA) and long-acting beta agonist (LABA), and failure, contraindication, or intolerance to Inhaled corticosteroids (ICS)

**AND**

6. Documentation the patient will not be concurrently treated with an alternative biologic for COPD

**AND**

7. Documented use will be used as add-on maintenance therapy in combination with **one (1)** of the following:
    a. Tripple therapy with a long-acting muscarinic agonist (LAMA), long-acting beta agonist (LABA), and Inhaled corticosteroids (ICS)
    b. Dual therapy with a long-acting muscarinic agonist (LAMA) and long-acting beta agonist (LABA), and failure, contraindication, or intolerance to Inhaled corticosteroids (ICS)

Reauthorization Criteria

1. Documented positive clinical response demonstrated by at least 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**

2. Documentation Nucala use will continue to be used as add-on maintenance therapy in combination with **one (1)** of the following:
    a. Tripple therapy with a long-acting muscarinic agonist (LAMA), long-acting beta agonist (LABA), and Inhaled corticosteroids (ICS)
    b. Dual therapy with a long-acting muscarinic agonist (LAMA) and long-acting beta agonist (LABA), and failure, contraindication, or intolerance to Inhaled corticosteroids (ICS)

## Limitations

- Initial approval of Respiratory Interleukins for severe asthma, chronic rhinosinusitis with nasal polyps, COPD, and eosinophilic granulomatosis with polyangiitis will be authorized for six (6) months. Reauthorization of a Respiratory Interleukin for one of these indications will be provided in 12-month intervals.
- Members new to the plan stable on a respiratory interleukin should be reviewed against Reauthorization Criteria for all indications.

## Codes

The following code(s) require prior authorization:

**Table 1: HCPCS Codes**

| HCPCS Codes | Description |
|---|---|
| J2786 | Injection, reslizumab, 1 mg |
| J2182 | Injection, mepolizumab, 1 mg |
| J0517 | Injection, benralizumab, 1 mg |
| J2361 | Injection, depemokimab-ulaa, 1 mg |

**Note:** Medical billing codes may not be used for Fasenra autoinjector and Nucala pre-filled autoinjectors and glass syringes for self-administration. These formulations must be obtained via the Member's pharmacy benefit.

## References


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2. 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.
3. Cinqair prescribing information. Frazer, PA: Teva Respiratory, LLC; February 2020.
4. Corren J, Weinstein S, Janka L, et al. Phase 3 study of reslizumab in patients with poorly controlled asthma: effects across a broad range of eosinophil counts. Chest. 2016 Mar;S0012- 3692(16)45715-6.
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6. Fasenra (benralizumab) [prescribing information]. Wilmington, DE: AstraZeneca Pharmaceuticals LP; September 2024.
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8. National Heart, Lung, and Blood Institute (NHLBI) & National Asthma Education and Prevention Program (NAEPP). Guidelines for the Diagnosis and Management of Asthma (EPR-3). 2007. Accessed April 17, 2024.
9. Global Initiative for Asthma (GINA). Global Strategy for Asthma Management and Prevention - GINA Report Updated 2023. 2023. Accessed April 17, 2024
10. Nucala (mepolizumab) [prescribing information]. Research Triangle Park, NC: GlaxoSmithKline; August 2025.
11. Bleecker, ER, FitzGerald JM, Chanez P, et al. Efficacy and safety of benralizumab for patients with severe asthma uncontrolled with high-dosage inhaled corticosteroids and long-acting β2-agonists (SIROCCO): a randomised, multicentre, placebo-controlled phase 3 trial. Lancet. 2016 Oct; 388(10056):2115-27.
12. Bergmark RW, Pynnonen M. Diagnosis and First-Line Treatment of Chronic Sinusitis. JAMA 2017; 318:2344.
13. Rosenfeld RM, Piccirillo JF, Chandrasekhar SS, et al. Clinical practice guideline (update): adult sinusitis. Otolaryngol Head Neck Surg 2015; 152:S1.


## Approval And Revision History

September 13, 2022: Reviewed by Pharmacy and Therapeutics Committee (P&T).

September 21, 2022: Reviewed by the Medical Policy Approval Committee (MPAC).

Subsequent endorsement date(s) and changes made:

- November 14, 2023: Administrative update to clarify duration of approval limits for severe asthma, chronic rhinosinusitis with nasal polyps, and eosinophilic granulomatosis with polyangiitis (effective 12/1/23).
- May 14, 2024: For Asthma, updated diagnosis criterion to include current treatment with an alternative biologic indicated for moderate to severe allergic or eosinophilic asthma or the patient is dependent on systemic steroids for all agents, and for Nucala a blood eosinophil level of at least 150 or 300 cells/mcL in the past 6 weeks or 12 months, respectively. Updated age requirements for Fasenra to at least 6 years of age. Removed the requirement that underlying conditions or triggers for asthma or pulmonary disease have already been addressed. Updated prerequisite requirements to be less strict. Added the patient will not concurrently treated with an alternative biologic for asthma. For CRSwNP, adjusted diagnostic requirements. Removed documentation of poor control requiring additional treatment despite a 12-week trial of an intranasal corticosteroid. Updated language for requirement of concurrent treatment with an intranasal corticosteroid. Added the patient is not being concurrently treated with an alternative biologic for nasal polyps. For eosinophilic granulomatosis with polyangiitis, added documented diagnosis of eosinophilic granulomatosis with polyangiitis. Reduced the number of disease characteristics from 4 to 2. Removed documentation of severe disease or disease flares with tapering of corticosteroid therapy. Modified language for the requirement for a relapse or refractory disease to standard of care. Updated the definition of a therapeutic response in the Reauthorization Criteria. For hypereosinophilic syndrome, added provider specialty requirements. Removed the Limitation Coverage will not be authorized if the Member is also receiving another biologic medication for the treatment of asthma. Combination respiratory interleukin therapy will not be authorized. Minor wording updates (eff 8/1/2024).
- September 2024: Rebranded from Tufts Health Unify to Tufts Health One Care.
- May 13, 2025: Added Fasenra to the existing coverage criteria for eosinophilic granulomatosis with polyangiitis due to the supplemental indication. Administrative update to remove Harvard Pilgrim Health Care Stride Medicare Advantage from the Medical Necessity Guideline template. (eff 6/1/25).
- December 2025: Evote, Added criteria for expanded indication of add-on maintenance treatment of adult patients with inadequately controlled chronic obstructive pulmonary disease (COPD) and an eosinophilic phenotype (effective

2/1/2026)

- 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: Removed Commercial Products and Tufts Health Direct from the Medical Necessity Guideline. No changes (eff 9/1/26). Administrative update: updated template to read: “Tufts Health Together- MassHealth Accountable Care Partnership Plans; Fax 617-673-0939”, to reflect change.
- August 11, 2026: Added Exdensur to coverage criteria for asthma (eff 9/1/26).

## Background, Product and Disclaimer Information

Medical Necessity Guidelines are developed to determine coverage for benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. We make coverage decisions using these guidelines, along with the Member’s benefit document, and in coordination with the Member’s physician(s) on a case-by-case basis considering the individual Member's health care needs.

Medical Necessity Guidelines are developed for selected therapeutic or diagnostic services found to be safe and proven 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 our service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. We revise and update 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 Medical Necessity Guideline and a self-insured Member’s benefit document, the provisions of the benefit document will govern. For Tufts Health Together (Medicaid), coverage may be available beyond these guidelines for pediatric members under age 21 under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits of the plan in accordance with 130 CMR 450.140 and 130 CMR 447.000, and with prior authorization.

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