Texas Prior Authorization Program
Clinical Criteria

Monoclonal Antibody Agents

This criteria was recommended for review by the Vendor Drug Program to ensure appropriate and safe utilization

Clinical Information Included in this Document

Adbry (Tralokinumab-ldrm)

- **Drugs requiring prior authorization:** the list of drugs requiring prior authorization for this clinical criteria
- **Prior authorization criteria logic:** a description of how the prior authorization request will be evaluated against the clinical criteria rules
- **Logic diagram:** a visual depiction of the clinical criteria logic
- **Supporting tables:** a collection of information associated with the steps within the criteria (diagnosis codes, procedure codes, and therapy codes); provided when applicable
- **References:** clinical publications and sources relevant to this clinical criteria

Note: Click the hyperlink to navigate directly to that section

Dupixent (Dupilumab)

- **Drugs requiring prior authorization:** the list of drugs requiring prior authorization for this clinical criteria
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Ebglyss (lebrikizumab-lbkz)

- **Drugs requiring prior authorization:** the list of drugs requiring prior authorization for this clinical criteria
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Fasenra (Benralizumab)

- **Drugs requiring prior authorization:** the list of drugs requiring prior authorization for this clinical criteria
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Nucala (Mepolizumab)

- **Drugs requiring prior authorization:** the list of drugs requiring prior authorization for this clinical criteria
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Tezspire (Tezepelumab-ekko)

- **Drugs requiring prior authorization:** the list of drugs requiring prior authorization for this clinical criteria
- **Prior authorization criteria logic:** a description of how the prior authorization request will be evaluated against the clinical criteria rules
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- **Supporting tables:** a collection of information associated with the steps within the criteria (diagnosis codes, procedure codes, and therapy codes)
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Xolair (Omalizumab)

- **Drugs requiring prior authorization:** the list of drugs requiring prior authorization for this clinical criteria
- **Prior authorization criteria logic:** a description of how the prior authorization request will be evaluated against the clinical criteria rules
- **Logic diagram:** a visual depiction of the clinical criteria logic
- **Supporting tables:** a collection of information associated with the steps within the criteria (diagnosis codes, procedure codes, and therapy codes)
- **References:** clinical publications and sources relevant to this clinical criteria

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Revision Notes

Added criteria for Ebglyss as approved by the DURB Board

Monoclonal Antibody Agents
Adbry (Tralokinumab-ldrm)
Drugs Requiring Prior Authorization

The listed GCNs may not be an indication of Texas Medicaid Formulary coverage. To learn the current formulary coverage, visit ***txvendordrug.com/formulary/formulary-search****.*

Drugs Requiring Prior Authorization	
Label Name	**GCN**
ADBRY 150 MG/ML SYRINGE	51749
ADBRY 300 MG/2 ML AUTOINJECTOR	55922

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Monoclonal Antibody Agents
Adbry (Tralokinumab-ldrm)
Clinical Criteria Logic

Initial Requests:

1. Is the request for 150 mg/mL syringe?
   [ ] Yes – Go to #3
   [ ] No – Go to #2

2. Is the request for 300 mg/2 mL autoinjector?
   [ ] Yes – Go to #4
   [ ] No – Deny

3. Is the client greater than or equal to (≥) 12 years of age?
   [ ] Yes – Go to #5
   [ ] No – Deny

4. Is the client greater than or equal to (≥) 18 years of age?
   [ ] Yes – Go to #5
   [ ] No – Deny

5. Does the client have a diagnosis of moderate to severe **atopic dermatitis** in the last 365 days that involves greater than or equal to (≥) 10% of the client's body surface area? [Manual]
   [ ] Yes – Go to #6
   [ ] No – Deny

6. Does the client have a claim for a **topical corticosteroid** and either **crisaborole, pimecrolimus or tacrolimus (topical)** in the last 365 days?
   [ ] Yes – Go to #7
   [ ] No – Deny

7. Does the client have a diagnosis of **helminth infection** in the last 180 days?
   [ ] Yes – Go to #8
   [ ] No – Approve (365 days)

8. Does the client have a claim for an **anthelmintic agent** in the last 180 days?
   [ ] Yes – Approve (365 days)
   [ ] No – Deny

Renewal Requests:

1. Does the client have a diagnosis of **atopic dermatitis** in the last 365 days?
   [ ] Yes – Go to #2
   [ ] No – Deny

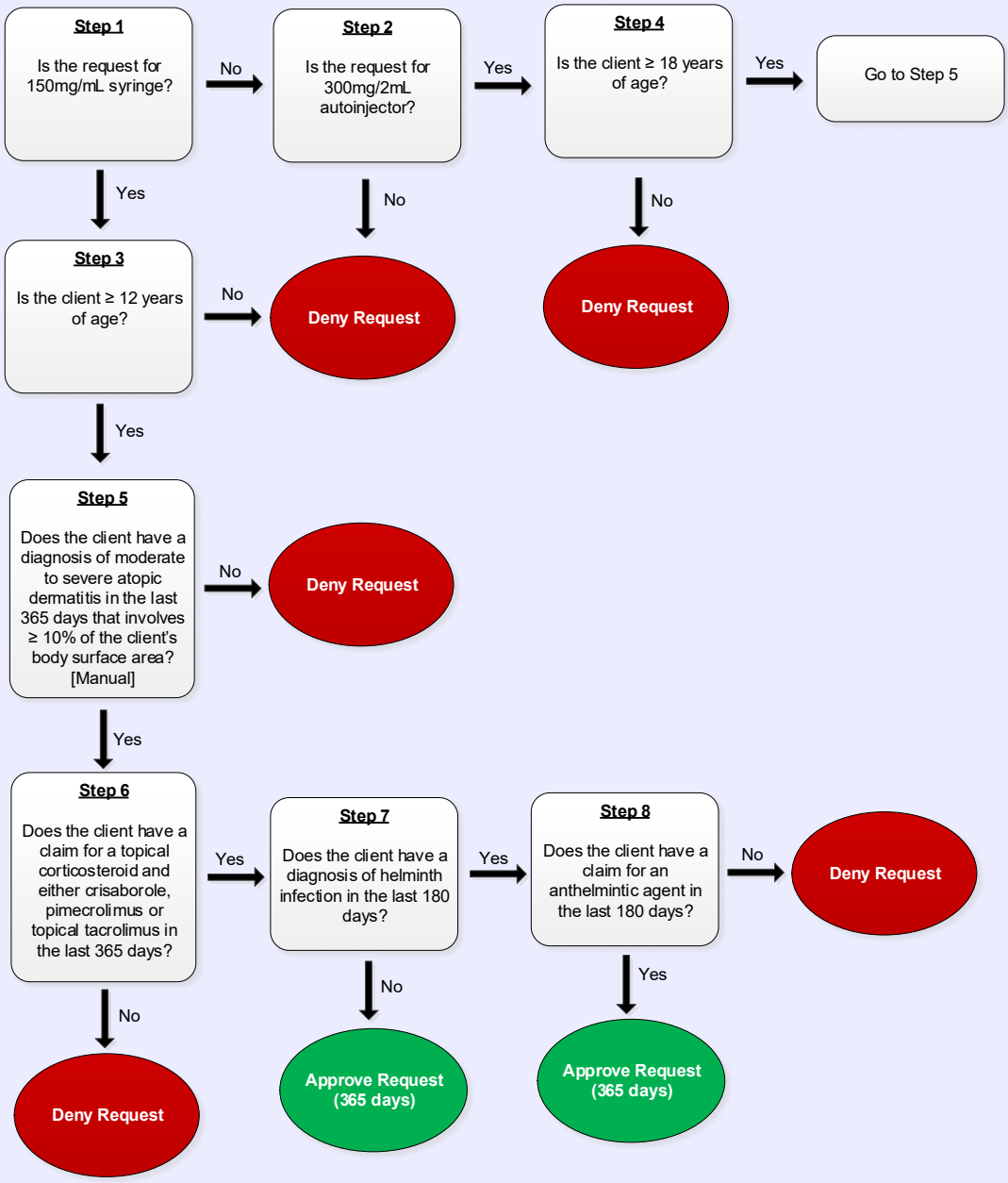
2. Does the client have a diagnosis of **helminth infection** in the last 180 days?
   [ ] Yes – Go to #3
   [ ] No – Go to #4

3. Does the client have a claim for an **anthelmintic agent** in the last 180 days?
   [ ] Yes – Go to #4
   [ ] No – Deny

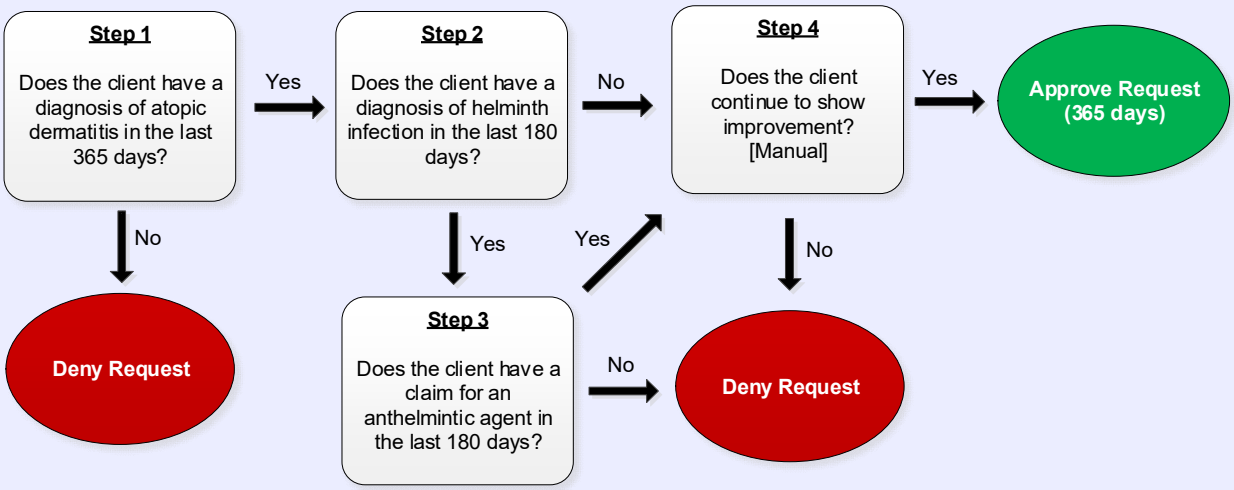
4. Does the client continue to show improvement? [Manual step]
   [ ] Yes – Approve (365 days)
   [ ] No – Deny

Monoclonal Antibody Agents
Adbry (Tralokinumab-ldrm)
Clinical Criteria Logic Diagram

Initial Requests:



Renewal Requests:



Monoclonal Antibody Agents
Dupixent (Dupilumab)
Drugs Requiring Prior Authorization

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Drugs Requiring Prior Authorization	
Label Name	**GCN**
DUPIXENT 100 MG/0.67 ML SYRINGE	51385
DUPIXENT 200 MG/1.14 ML PEN	48785
DUPIXENT 200 MG/1.14 ML SYRINGE	45522
DUPIXENT 300 MG/2 ML PEN	48277
DUPIXENT 300 MG/2 ML SYRINGE	43222

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Monoclonal Antibody Agents
Dupixent (Dupilumab)
Clinical Criteria Logic

Initial Requests:

1. Is the client greater than or equal to (≥) 6 months of age?
   [ ] Yes – Go to #2
   [ ] No – Deny

2. Does the client have a diagnosis of moderate to severe **atopic dermatitis** in the last 365 days that involves greater than or equal to (≥) 10% of the client's body surface area? [Manual step]
   [ ] Yes – Go to #3
   [ ] No – Go to #4

3. Does the client have a claim for a **topical corticosteroid** and **crisaborole, pimecrolimus, or tacrolimus (topical)** in the last 365 days?
   [ ] Yes – Approve (365 days)
   [ ] No – Go to #4

4. Is the client greater than or equal to (≥) 6 years of age?
   [ ] Yes – Go to #5
   [ ] No – Go to #7

5. Does the client have a diagnosis of **moderate-to-severe asthma** in the last 365 days?
   [ ] Yes – Go to #6
   [ ] No – Go to #7

6. Does the client have at least 30 days supply of an **oral** or **inhaled corticosteroid** in the last 60 days?
   [ ] Yes – Approve (365 days)
   [ ] No – Go to #7

7. Is the client greater than or equal to (≥) 1 year of age?
   [ ] Yes – Go to #8
   [ ] No – Go to#10

8. Does the client have a diagnosis of **eosinophilic esophagitis** in the last 365 days?
   [ ] Yes – Go to #9
   [ ] No – Go to #10

9. Does the client weigh greater than or equal to (≥) 15 kg? [Manual]
   [ ] Yes – Approve (365 days)
   [ ] No – Go to #10

10. Is the client greater than or equal to (≥) 12 years of age?
    [ ] Yes – Go to #11
    [ ] No – Deny

11. Does the client have a diagnosis of **chronic rhinosinusitis with nasal polyps** in the last 365 days?
    [ ] Yes – Go to #12
    [ ] No – Go to #13

12. Does the client have at least 60 days supply of an **intranasal corticosteroid** in the last 90 days?
    [ ] Yes – Approve (365 days)
    [ ] No – Go to #13

13. Is the client greater than or equal to (≥) 18 years of age?
    [ ] Yes – Go to #14
    [ ] No – Deny

14. Does the client have a diagnosis of **prurigo nodularis** or **chronic obstructive pulmonary disease (COPD)** in the last 365 days?
    [ ] Yes – Approve (365 days)
    [ ] No – Deny

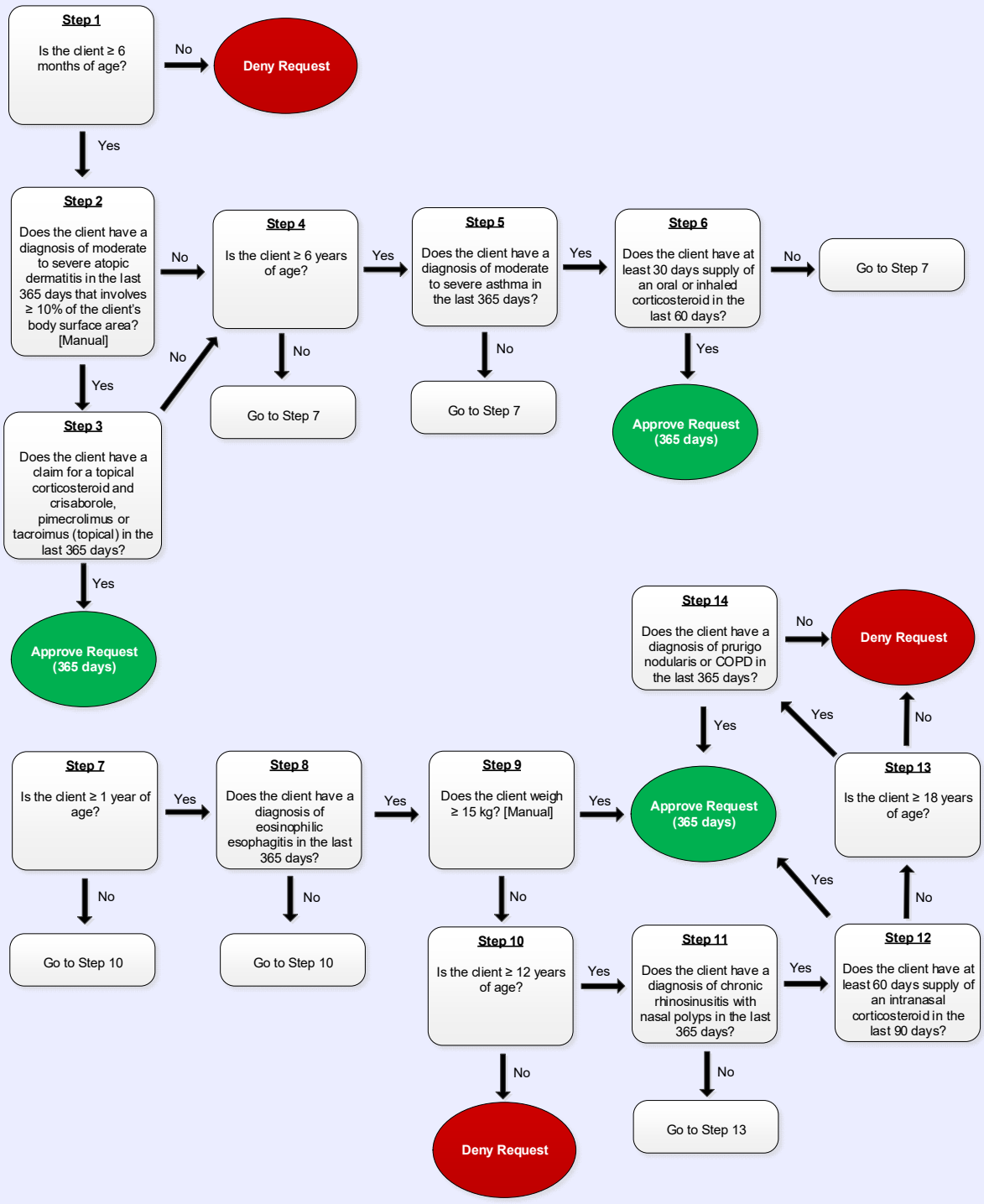
Renewal Requests:

1. Does the client have a diagnosis of **atopic dermatitis**, **asthma**, **chronic obstructive pulmonary disease**, **chronic rhinosinusitis with nasal polyps**, **eosinophilic esophagitis** or **prurigo nodularis** in the last 365 days?
   [ ] Yes – Go to #2
   [ ] No – Deny

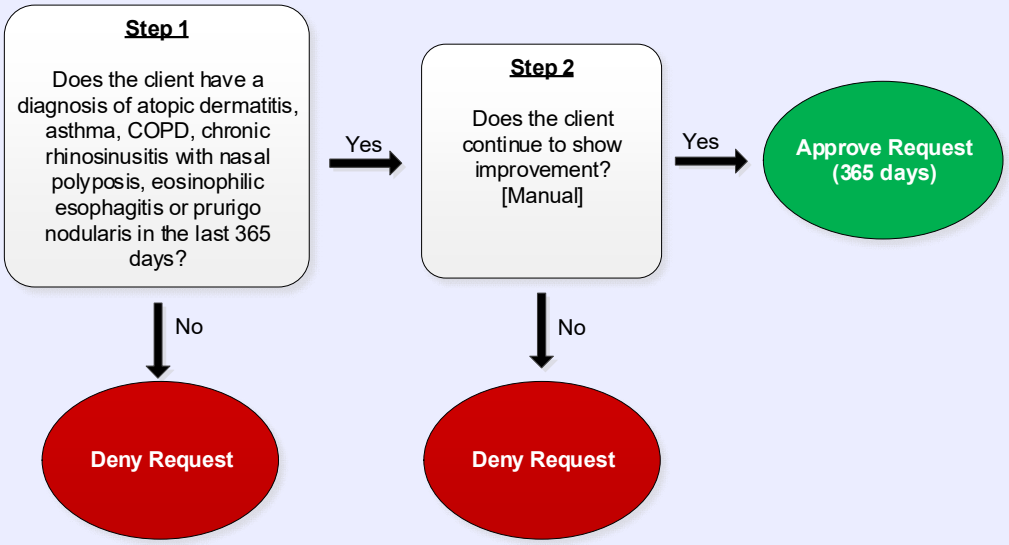
2. Does the client continue to show improvement? [Manual step]
   [ ] Yes – Approve (365 days)
   [ ] No – Deny

Monoclonal Antibody Agents
Dupixent (Dupilumab)
Clinical Criteria Logic Diagram

Initial Requests:



Renewal Requests:



Monoclonal Antibody Agents
Ebglyss (lebrikizumab-lbkz)
Drugs Requiring Prior Authorization

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Drugs Requiring Prior Authorization	
Label Name	**GCN**
EBGLYSS 250 MG/2 ML PEN	55845
EBGLYSS 250 MG/2 ML SYRINGE	56133

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Monoclonal Antibody Agents
Ebglyss (lebrikizumab-lbkz)
Clinical Criteria Logic

Initial Requests:

1. Is the client greater than or equal to (≥) 12 years of age?
   [ ] Yes – Go to #2
   [ ] No – Deny

2. Does the client have a diagnosis of moderate to severe **atopic dermatitis** in the last 365 days that involves greater than or equal to (≥) 10% of the client's body surface area? [Manual]
   [ ] Yes – Go to #3
   [ ] No – Deny

3. Does the client have a claim for a **topical corticosteroid** in the last 365 days?
   [ ] Yes – Go to #4
   [ ] No – Deny

4. Does the client have a claim for **crisaborole, pimecrolimus or tacrolimus (topical)** in the last 365 days?
   [ ] Yes – Go to #5
   [ ] No – Deny

5. Does the client have a **diagnosis of helminth infection** in the last 180 days?
   [ ] Yes – Go to #6
   [ ] No – Go to #7

6. Does the client have a claim for an **anthelmintic agent** in the last 180 days?
   [ ] Yes – Go to #7
   [ ] No – Deny

7. Will the client have concurrent therapy with another **monoclonal antibody agent**?
   [ ] Yes – Deny
   [ ] No – Approve (365 days)

Renewal Requests:

1. Does the client have a **diagnosis of helminth infection** in the last 180 days?
   [ ] Yes – Go to #2
   [ ] No – Go to #3

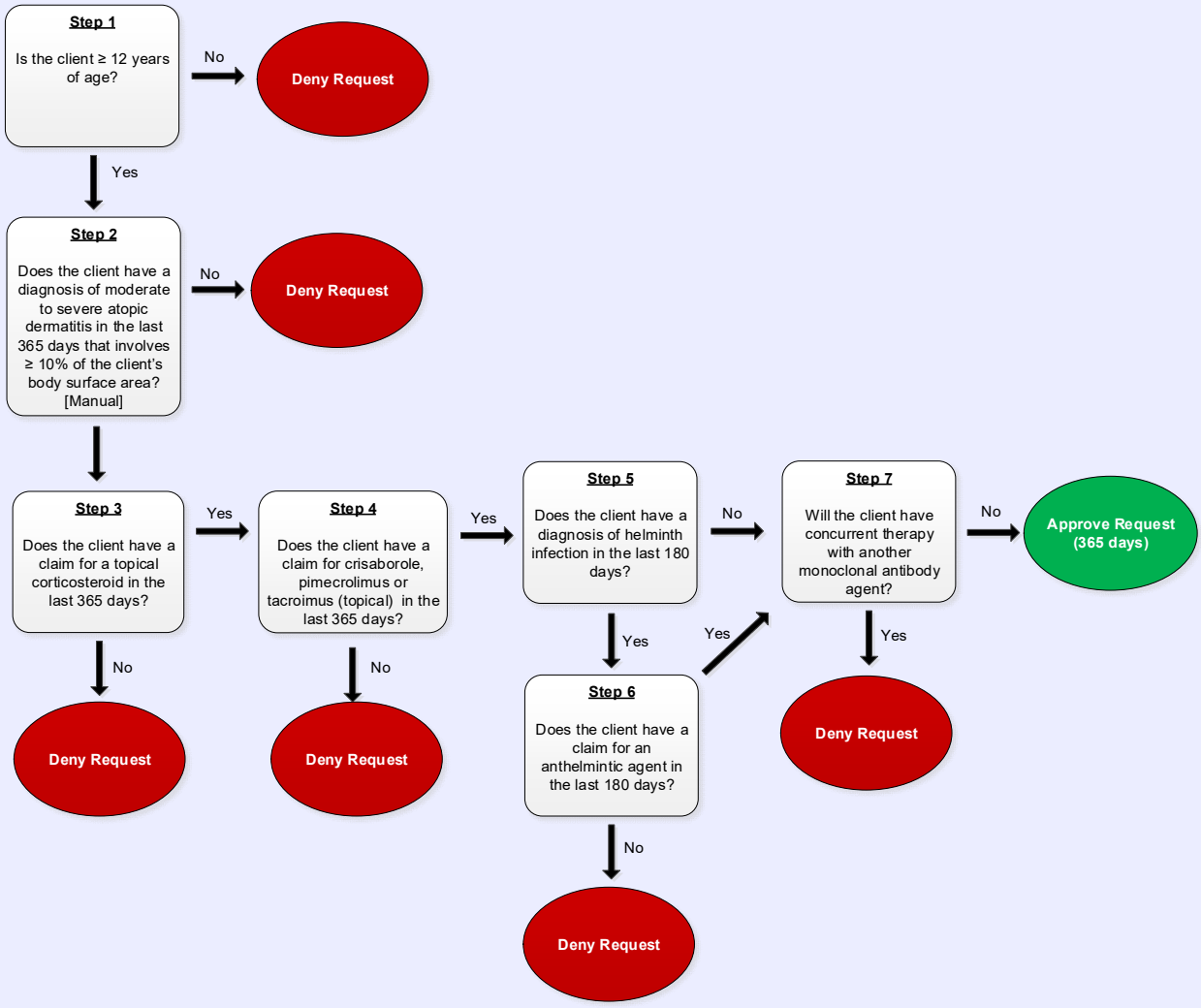
2. Does the client have a claim for an **anthelmintic agent** in the last 180 days?
   [ ] Yes – Go to #3
   [ ] No – Deny

3. Will the client have concurrent therapy with another **monoclonal antibody agent**?
   [ ] Yes – Deny
   [ ] No – Go to #4

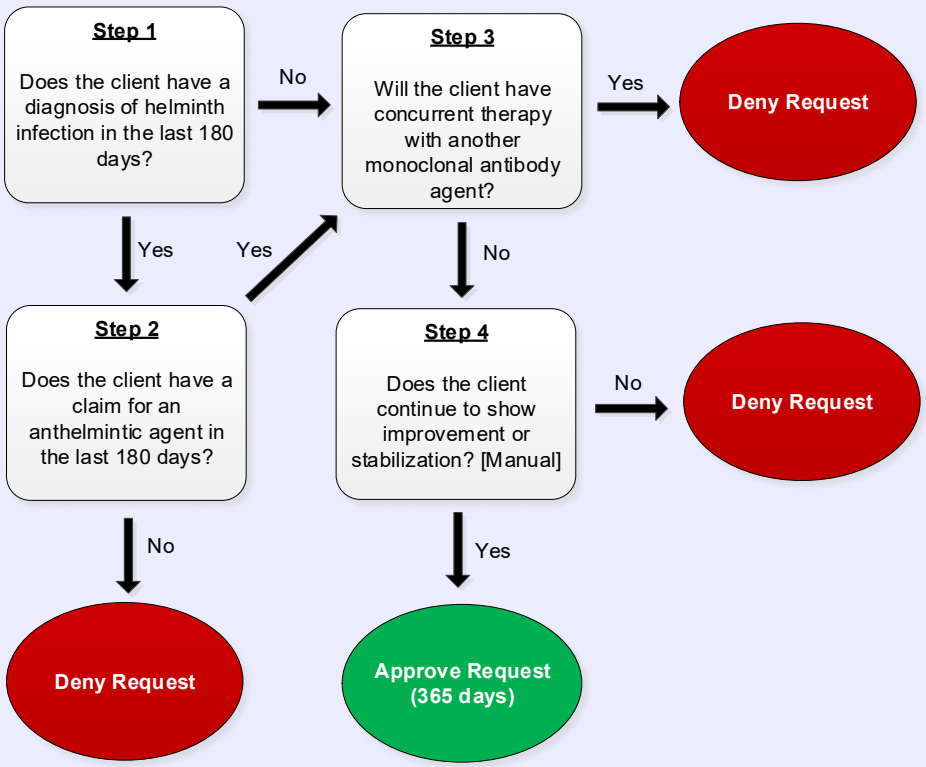
4. Does the client continue to show improvement or stabilization? [Manual]
   [ ] Yes – Approve (365 days)
   [ ] No – Deny

Monoclonal Antibody Agents
Ebglyss (lebrikizumab-lbkz)
Clinical Criteria Logic Diagram

Initial Request:



Renewal Request:



Monoclonal Antibody Agents
Fasenra (Benralizumab)
Drugs Requiring Prior Authorization

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Drugs Requiring Prior Authorization	
Label Name	**GCN**
FASENRA PEN 30 MG/ML	47019

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Monoclonal Antibody Agents
Fasenra (Benralizumab)
Clinical Criteria Logic

1. Is the client greater than or equal to (≥) 6 years of age?
   [ ] Yes – Go to #2
   [ ] No – Deny

2. Does the client have a diagnosis of **severe asthma** or **eosinophilic asthma** in the last 730 days?
   [ ] Yes – Go to #3
   [ ] No – Go to #4

3. Does the client have a claim for an **asthma controller medication** in the last 90 days?
   [ ] Yes – Go to #6
   [ ] No – Go to #4

4. Is the client greater than or equal to (≥) 18 years of age?
   [ ] Yes – Go to #5
   [ ] No – Deny

5. Does the client have a diagnosis of **eosinophilic granulomatosis with polyangiitis (EGPA)** in the last 730 days?
   [ ] Yes – Go to #6
   [ ] No – Deny

6. Does the client have a diagnosis of **helminth infection** in the last 180 days?
   [ ] Yes – Go to #7
   [ ] No – Go to #8

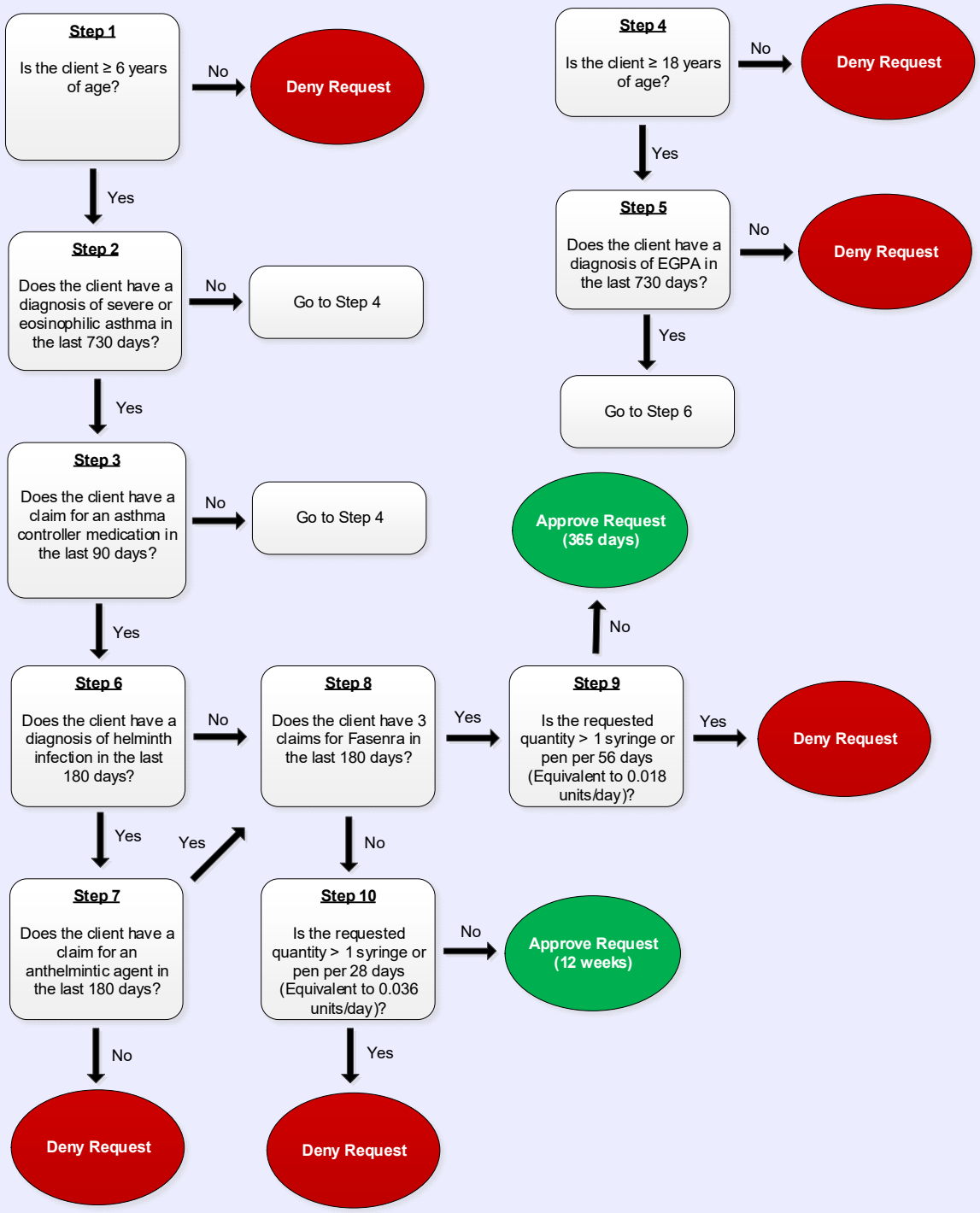
7. Does the client have a claim for an **anthelmintic agent** in the last 180 days?
   [ ] Yes – Go to #8
   [ ] No – Deny

8. Does the client have 3 claims for Fasenra (benralizumab) in the last 180 days?
   [ ] Yes – Go to #9
   [ ] No – Go to #10

9. Is the requested quantity greater than (>) 1 syringe or pen per 56 days (Equivalent to 0.018 units/day)?
   [ ] Yes – Deny
   [ ] No – Approve (365 days)

10. Is the requested quantity greater than (>) 1 syringe or pen per 28 days (Equivalent to 0.036 units/day)?
    - [ ] Yes – Deny
    - [ ] No – Approve (12 weeks)

Monoclonal Antibody Agents
Fasenra (Benralizumab)
Clinical Criteria Logic Diagram



Monoclonal Antibody Agents
Nucala (Mepolizumab)
Drugs Requiring Prior Authorization

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Drugs Requiring Prior Authorization	
Label Name	**GCN**
NUCALA 100 MG/ML AUTO-INJECTOR	46414
NUCALA 100 MG/ML SYRINGE	46413
NUCALA 40 MG/0.4 ML SYRINGE	52416

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Monoclonal Antibody Agents
Nucala (Mepolizumab)
Clinical Criteria Logic

1. Is the client greater than or equal to (≥) 6 years of age?
   [ ] Yes – Go to #2
   [ ] No – Deny

2. Does the client have a diagnosis of **severe asthma** in the last 730 days?
   [ ] Yes – Go to #3
   [ ] No – Go to #4

3. Does the client have a claim for an **asthma controller medication** in the last 90 days?
   [ ] Yes – Go to #12
   [ ] No – Deny

4. Is the client greater than or equal to (≥) 12 years of age?
   [ ] Yes – Go to #5
   [ ] No – Deny

5. Does the client have a diagnosis of **hypereosinophilic syndrome (HES)** in the last 730 days?
   [ ] Yes – Go to #9
   [ ] No – Go to #6

6. Does the client have a diagnosis of **eosinophilic granulomatosis with polyangiitis (EGPA)** in the last 730 days?
   [ ] Yes – Go to #8
   [ ] No – Go to #7

7. Does the client have a diagnosis of **chronic rhinosinusitis with nasal polyps (CRSwNP)** in the last 730 days?
   [ ] Yes – Go to #8
   [ ] No – Deny

8. Is the client greater than or equal to (≥) 18 years of age?
   [ ] Yes (And the client has a diagnosis of EGPA) – Go to #9
   [ ] Yes (And the client has a diagnosis of CRSwNP) – Go to #11
   [ ] No – Deny

9. Has the client had a trial of **oral glucocorticoid therapy** in the last 45 days, or is oral glucocorticoid therapy contraindicated?
   [ ] Yes – Go to #10
   [ ] No – Deny

10. Has the client had a **trial of cyclophosphamide, azathioprine, methotrexate or leflunomide** in the last 90 days, or is a trial of these medications contraindicated?
    [ ] Yes – Go to #12
    [ ] No – Deny

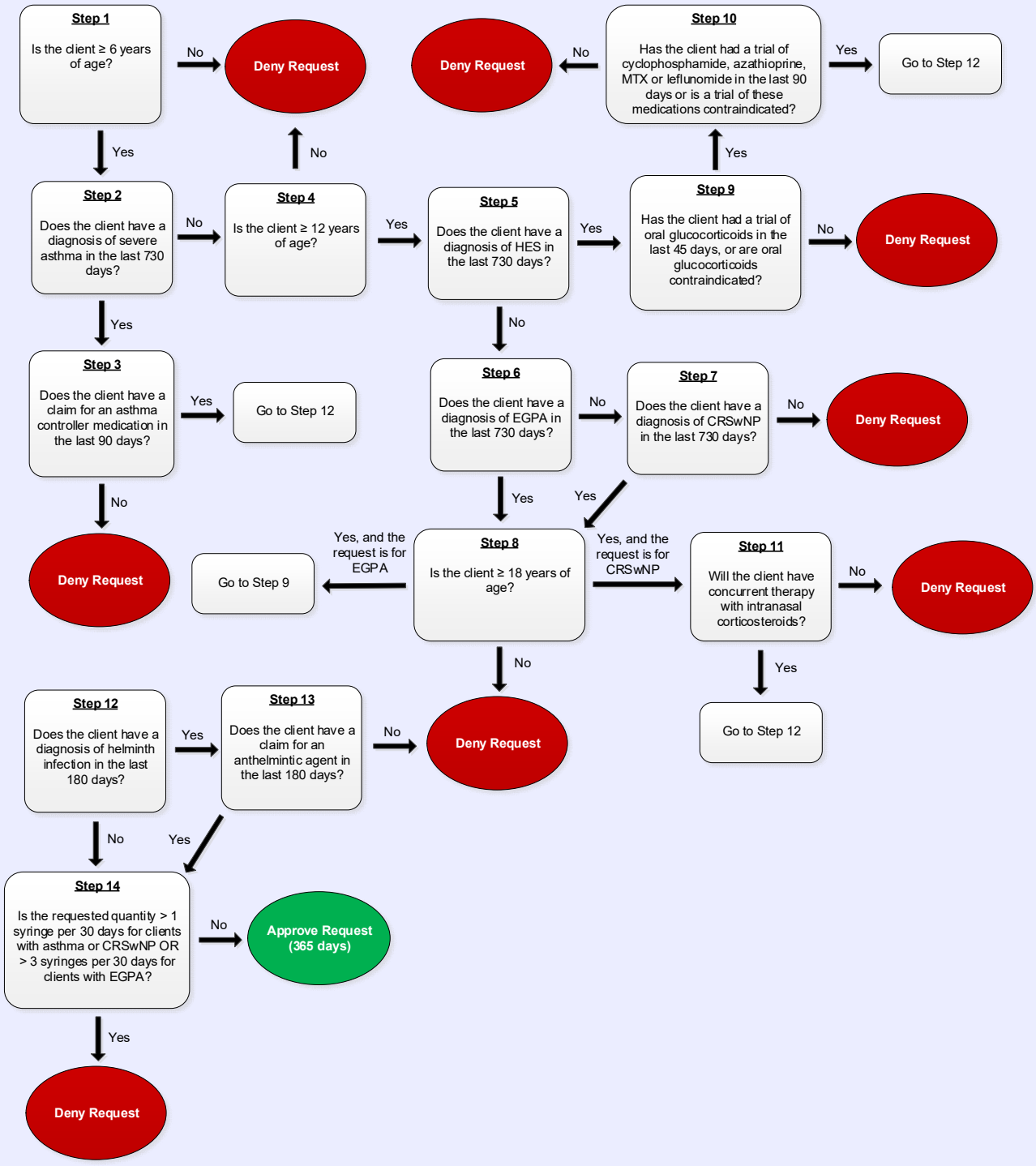
11. Will the client have concurrent therapy with **intranasal corticosteroids**?
    [ ] Yes – Go to #12
    [ ] No – Deny

12. Does the client have a diagnosis of **helminth infection** in the last 180 days?
    [ ] Yes – Go to #13
    [ ] No – Go to #14

13. Does the client have a claim for an **anthelmintic agent** in the last 180 days?
    [ ] Yes – Go to #14
    [ ] No – Deny

14. Is the requested quantity greater than (>) 1 syringe per 30 days for clients with asthma or CRSwNP OR greater than (>) 3 syringes per 30 days for clients with EGPA or HES?
    [ ] Yes – Deny
    [ ] No – Approve (365 days)

Monoclonal Antibody Agents
Nucala (Mepolizumab)
Clinical Criteria Logic Diagram



Monoclonal Antibody Agents
Tezspire (Tezepelumab-ekko)
Drugs Requiring Prior Authorization

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Drugs Requiring Prior Authorization	
Label Name	**GCN**
TEZSPIRE 210 MG/1.91 ML PEN	53116

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Monoclonal Antibody Agents
Tezspire (Tezepelumab-ekko)
Clinical Criteria Logic

Initial Criteria:

1. Is the client greater than or equal to (≥) 12 years of age?
   [ ] Yes – Go to #2
   [ ] No – Deny

2. Does the client have a diagnosis of **severe asthma** in the last 730 days?
   [ ] Yes – Go to #3
   [ ] No – Deny

3. Does the client have a claim for an **asthma controller medication** in the last 90 days?
   [ ] Yes – Go to #4
   [ ] No – Deny

4. Does the client have a diagnosis of **helminth infection** in the last 180 days?
   [ ] Yes – Go to #5
   [ ] No – Go to #6

5. Does the client have a claim for an **anthelmintic agent** in the last 180 days?
   [ ] Yes – Go to #6
   [ ] No – Deny

6. Is the requested quantity greater than (>) 1 pen per 28 days?
   [ ] Yes – Deny
   [ ] No – Approve (365 days)

Renewal Criteria:

1. Does the client have a diagnosis of **severe asthma** in the last 730 days?
   [ ] Yes – Go to #2
   [ ] No – Deny

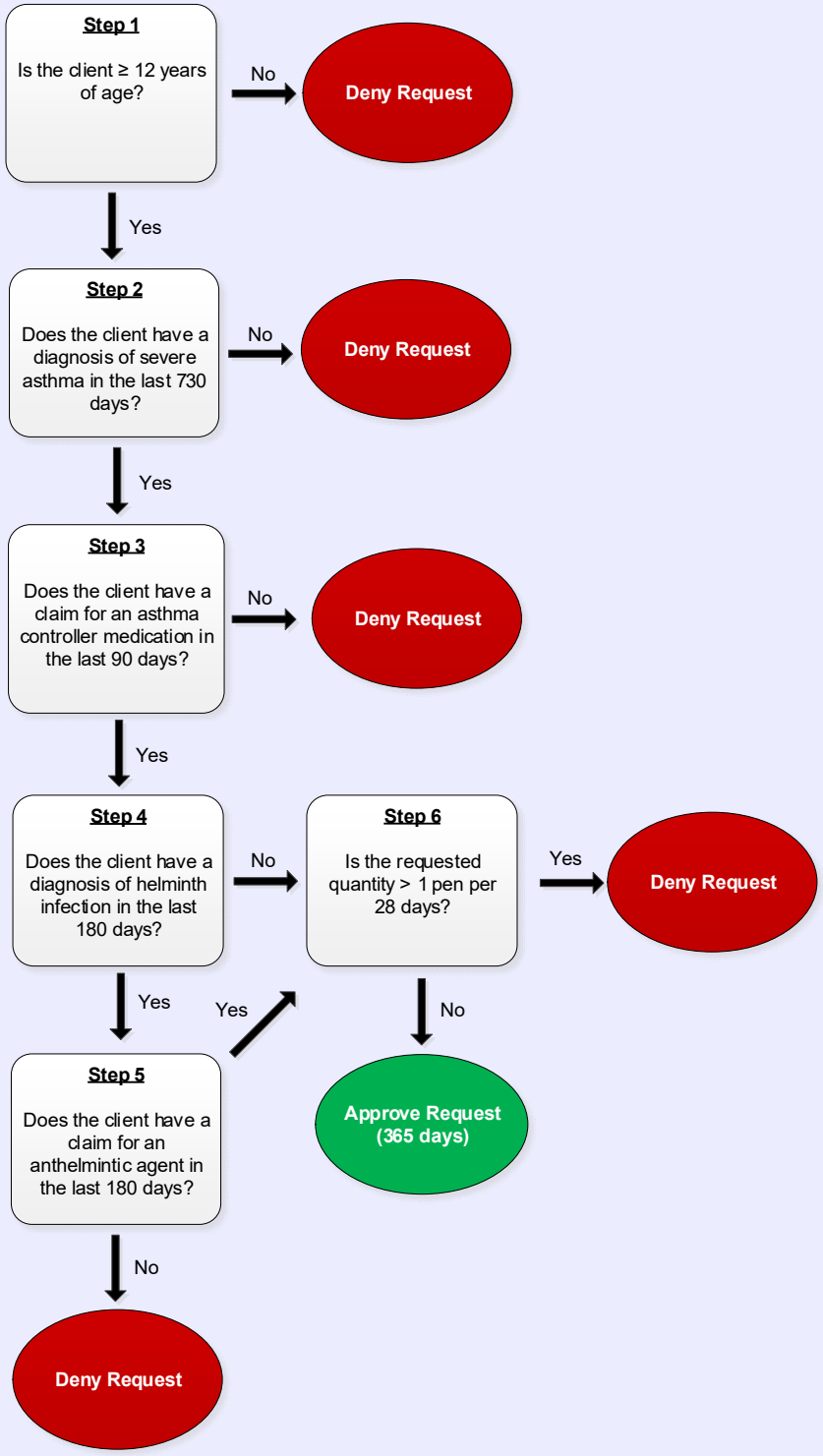
2. Does the client have a diagnosis of **helminth infection** in the last 180 days?
   [ ] Yes – Go to #3
   [ ] No – Go to #4

3. Does the client have a claim for an **anthelmintic agent** in the last 180 days?
   [ ] Yes – Go to #4
   [ ] No – Deny

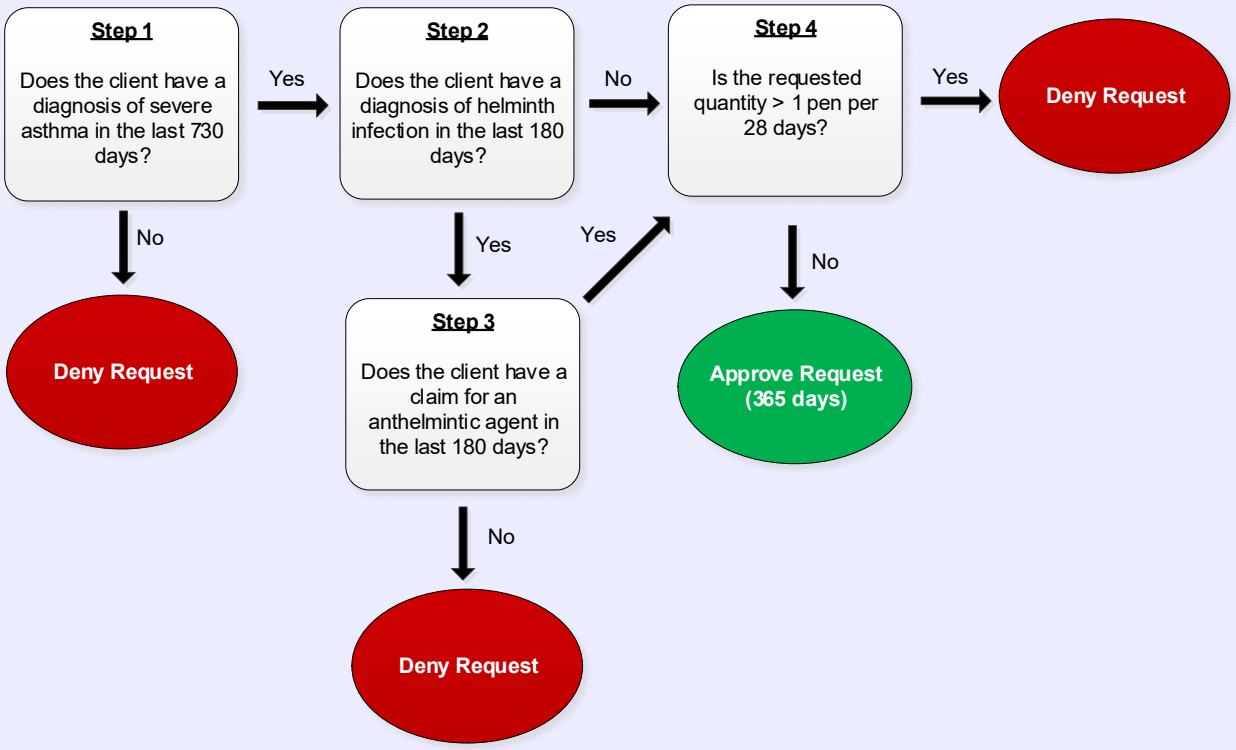
4. Is the requested quantity greater than (>) 1 pen per 28 days?
   [ ] Yes – Deny
   [ ] No – Approve (365 days)

Monoclonal Antibody Agents
Tezspire (Tezepelumab-ekko)
Clinical Criteria Logic Diagram

Initial Criteria:



Renewal Criteria:



Monoclonal Antibody Agents
Xolair (Omalizumab)

Drugs Requiring Prior Authorization

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Drugs Requiring Prior Authorization	
Label Name	**GCN**
XOLAIR 150 MG/ML AUTOINJECTOR	55223
XOLAIR 150 MG/ML SYRINGE	30556
XOLAIR 300 MG/2 ML AUTOINJECTOR	55225
XOLAIR 300 MG/2 ML SYRINGE	55224
XOLAIR 75 MG/0.5 ML AUTOINJECTOR	55222
XOLAIR 75 MG/0.5 ML SYRINGE	30555

RxPERT PAxPRESS

Monoclonal Antibody Agents
Xolair (Omalizumab)

Clinical Criteria Logic

Initial Criteria:

1. Is the client greater than or equal to (≥) 1 year of age?
   [ ] Yes – Go to #2
   [ ] No – Deny

2. Does the client have a diagnosis of **IgE-mediated food allergy** in the last 730 days?
   [ ] Yes – Go to #20
   [ ] No – Go to #3

3. Is the client greater than or equal to (≥) 6 years of age?
   [ ] Yes – Go to #4
   [ ] No – Deny

4. Does the client have a diagnosis of **moderate to severe persistent asthma** in the last 730 days?
   [ ] Yes – Go to #5
   [ ] No – Go to #11

5. Has the client had a **positive skin test or in vitro reactivity** to a perennial aeroallergen in the last 5 years?
   [ ] Yes – Go to #6
   [ ] No – Go to #11

6. Does the client have at least 60 days therapy with an **inhaled corticosteroid (ICS)** in the last 90 days OR does the client have an intolerance, hypersensitivity, or contraindication to inhaled corticosteroids?
   [ ] Yes – Go to #7
   [ ] No – Go to #11

7. Does the client have at least 60 days therapy with a **long-acting beta agonist (LABA), leukotriene modifier (LTM), long-acting muscarinic antagonist (LAMA) or theophylline** in the last 90 days OR does the client have an intolerance or hypersensitivity to all classes listed?
   [ ] Yes – Go to #8
   [ ] No – Go to #11

8. Is the client's pretreatment IgE level ≥ 30 IU/mL and ≤ 700 IU/mL (12 years and older) OR ≥ 30 IU/mL and ≤ 1300 IU/mL (6 to < 12 years of age)? [Manual]
   [ ] Yes – Go to #9
   [ ] No – Go to #11

9. Does the client weigh more than 150kg? [Manual]
   [ ] Yes – Go to #11
   [ ] No – Go to #10

10. Is the requested dose (based on the client's pretreatment serum IgE level and body weight) equal to the **dose defined in the FDA labeling**, not to exceed 375 mg every 2 weeks? [Manual]
    [ ] Yes – Go to #21
    [ ] No – Go to #11

11. Does the client have a diagnosis of **chronic spontaneous urticaria (CSU)** in the last 730 days?
    [ ] Yes – Go to #12
    [ ] No – Go to #15

12. Is the client greater than or equal to (≥) 12 years of age?
    [ ] Yes – Go to #13
    [ ] No – Deny

13. Does the client have at least 60 days therapy with an **H1 antihistamine** in the last 90 days OR is does the client have an intolerance, hypersensitivity, or contraindication to all H1 antihistamines?
    [ ] Yes – Go to #14
    [ ] No – Go to #15

14. Is the requested dose equal to the dose defined in the FDA labeling, not to exceed 300 mg every 4 weeks? [Manual]
    [ ] Yes – Go to #21
    [ ] No – Go to #15

15. Does the client have a diagnosis of **nasal polyps** in the last 730 days?
    [ ] Yes – Go to #16
    [ ] No – Deny

16. Is the client greater than or equal to (≥) 18 years of age?
    [ ] Yes – Go to #17
    [ ] No – Deny

17. Does the client have at least 90 days therapy with an **intranasal corticosteroid (INC)** in the last 120 days OR does the client have an intolerance, hypersensitivity, or contraindication to nasal corticosteroids?
    [ ] Yes – Go to #18
    [ ] No – Deny

18. Is the client's pretreatment IgE level ≥ 30 IU/mL and ≤ 1500 IU/mL? [Manual]
    [ ] Yes – Go to #19
    [ ] No – Deny

19. Does the client weigh more than 150kg? [Manual]
    [ ] Yes – Deny
    [ ] No – Go to #20

20. Is the requested dose (based on the client's pretreatment serum IgE level and body weight) equal to the **dose defined in the FDA labeling**, not to exceed 600 mg every 2 weeks? [Manual]
    [ ] Yes – Go to #21
    [ ] No – Deny

21. Will the client have concurrent therapy with another **monoclonal antibody agent** indicated for the treatment of asthma, chronic spontaneous urticaria or nasal polyps?
    [ ] Yes – Deny
    [ ] No – Approve (365 days)

Renewal Criteria:

1. Does the client have a diagnosis of **IgE-mediated food allergy** in the last 730 days?
    [ ] Yes – Go to #11
    [ ] No – Go to #2

2. Does the client have a diagnosis of **moderate to severe persistent asthma** in the last 730 days?
    [ ] Yes – Go to #3
    [ ] No – Go to #6

3. Does the client have current therapy with an **inhaled corticosteroid** that will continue during therapy with Xolair OR does the client have an intolerance, hypersensitivity, or contraindication to inhaled corticosteroids?
    [ ] Yes – Go to #4
    [ ] No – Go to #6

4. Does the client weigh more than 150kg? [Manual]
    [ ] Yes – Go to #6
    [ ] No – Go to #5

5. Is the requested dose (based on the client's pretreatment serum IgE level and body weight) equal to the **dose defined in the FDA labeling**, not to exceed 375 mg every 2 weeks? [Manual]
    [ ] Yes – Go to #12
    [ ] No – Go to #6

6. Does the client have a diagnosis of **chronic spontaneous urticaria** in the last 730 days?
   [ ] Yes – Go to #7
   [ ] No – Go to #8

7. Is the requested dose equal to the dose defined in the FDA labeling, not to exceed 300 mg every 4 weeks? [Manual]
   [ ] Yes – Go to #12
   [ ] No – Go to #8

8. Does the client have a diagnosis of **nasal polyps** in the last 730 days?
   [ ] Yes – Go to #9
   [ ] No – Deny

9. Does the client have current therapy with an **intranasal corticosteroid** that will continue during therapy with Xolair OR does the client have an intolerance, hypersensitivity, or contraindication to nasal corticosteroids?
   [ ] Yes – Go to #10
   [ ] No – Deny

10. Does the client weigh more than 150kg? [Manual]
    [ ] Yes – Deny
    [ ] No – Go to #11

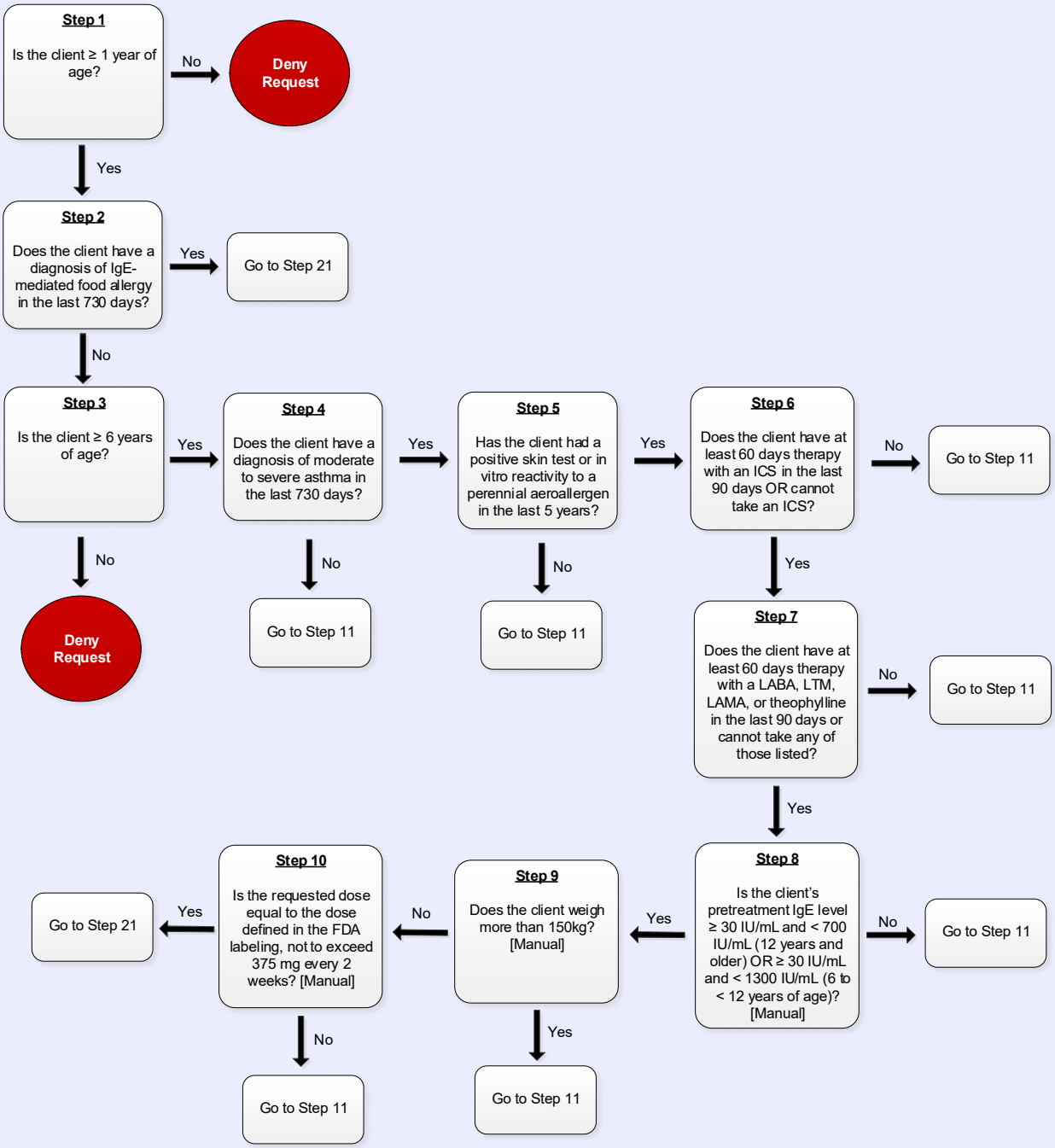
11. Is the requested dose (based on the client's pretreatment serum IgE level and body weight) equal to the **dose defined in the FDA labeling**, not to exceed 600 mg every 2 weeks? [Manual]
    [ ] Yes – Go to #12
    [ ] No – Deny

12. Will the client have concurrent therapy with another **monoclonal antibody agent** indicated for the treatment of asthma, chronic spontaneous urticaria or nasal polyps?
    [ ] Yes – Deny
    [ ] No – Approve (365 days)

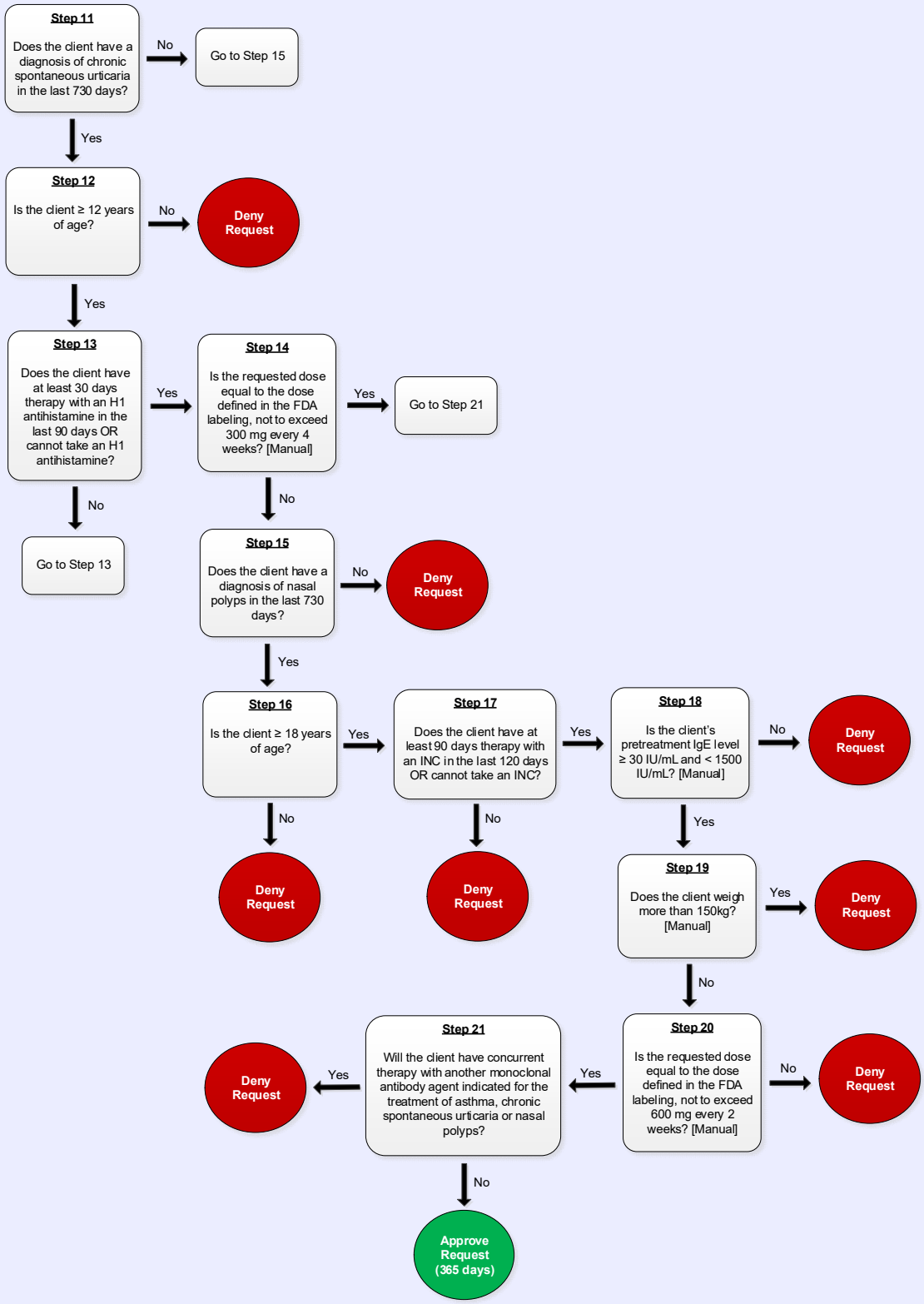
Monoclonal Antibody Agents
Xolair (Omalizumab)

Clinical Criteria Logic Diagram

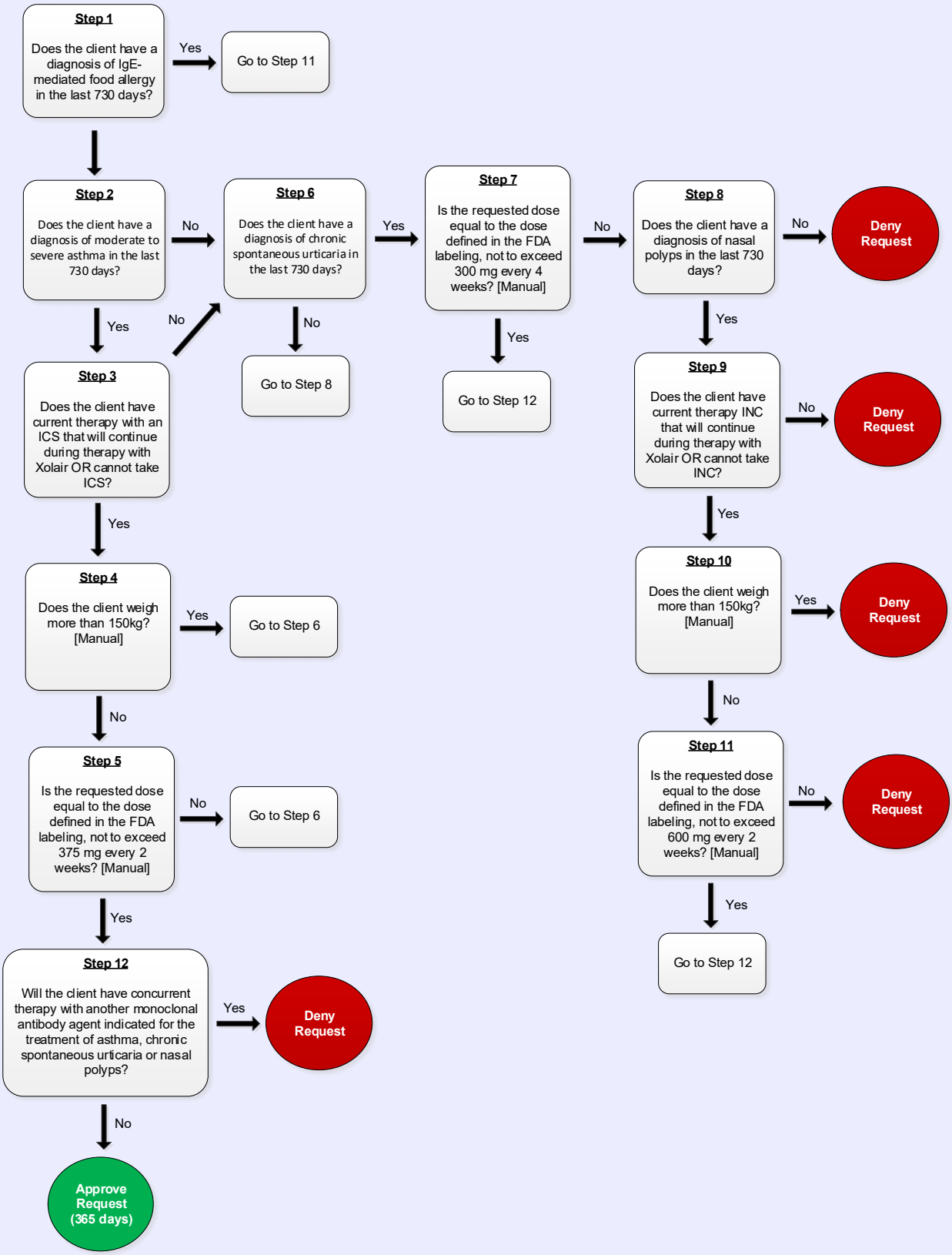
Initial Criteria:



Initial Criteria, Continued:



Renewal Criteria:



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Monoclonal Antibodies for Asthma

Clinical Criteria Supporting Tables

Allergen testing **Required quantity:** *1* **Look back timeframe:** *5 years*	
ICD-10 Code	**Description**
Z0182	ENCOUNTER FOR ALLERGY TESTING

Anthelmintic Agent	
Label Name	**GCN**
ALBENDAZOLE 200 MG TABLET	53290
ALBENZA 200 MG TABLET	53290
BILTRICIDE 600 MG TABLET	08490
EMVERM 100 MG TABLET CHEW	43181
IVERMECTIN 3 MG TABLET	93064
PRAZIQUANTEL 600 MG TABLET	08490
STROMECTOL 3 MG TABLET	93064

Asthma Controller Medication	
Label Name	**GCN**
ADVAIR 100-50 DISKUS	50584
ADVAIR 250-50 DISKUS	50594
ADVAIR 500-50 DISKUS	50604
ADVAIR HFA 115-21MCG INHALER	97136
ADVAIR HFA 230-21MCG INHALER	97137
ADVAIR HFA 45-21MCG INHALER	97135
AIRDUO DIGIHALER 113-14MCG	48494
AIRDUO DIGIHALER 232-14MCG	48495
AIRDUO DIGIHALER 55-14MCG	48489
AIRSUPRA 90-80MCG INHALER	53534
ALVESCO 160 MCG INHALER	24152
ALVESCO 80 MCG INHALER	24149
ARMONAIR RESPICLICK 232MCG	42985
ARMONAIR RESPICLICK 55MCG	42979

Asthma Controller Medication	
Label Name	**GCN**
ARMONAIR DIGIHALER 55MCG	48602
ARMONAIR DIGIHALER 113 MCG	48604
ARMONAIR DIGIHALER 232 MCG	48615
ARNUITY ELLIPTA 100 MCG INH	37007
ARNUITY ELLIPTA 200 MCG INH	37008
ARNUITY ELLIPTA 50 MCG INH	44783
ASMANEX HFA 100 MCG INHALER	37566
ASMANEX HFA 200 MCG INHALER	37565
ASMANEX TWISTHALER 110 MCG #30	99721
ASMANEX TWISTHALER 220 MCG #30	24928
ASMANEX TWISTHALER 220 MCG #60	24929
ASMANEX TWISTHALR 220 MCG #120	18987
ASMANEX HFA 50 MCG INHALER	47599
ASMANEX HFA 100 MCG INHALER	37566
ASMANEX HFA 200 MCG INHALER	37565
BREO ELLIPTA 100-25MCG INH	34647
BREO ELLIPTA 200-25MCG INHALER	35808
BREYNA 160-4.5MCG INHALER	98500
BREYNA 80-4.5MCG INHALER	98499
BREZTRI AEROSPHERE INHALER	48435
BUDESONIDE 0.25MG/2ML INHALATION SUSPENSION	17957
BUDESONIDE 0.5MG/2ML INHALATION SUSPENSION	17958
BUDESONIDE 1MG/2ML INHALATION SUSPENSION	62980
BUDESONIDE-FORMOTEROL 160-4.5MCG	98500
BUDESONIDE-FORMOTEROL 80-4.5MCG	98499
DULERA 100 MCG/5 MCG INHALER	28766
DULERA 200 MCG/5 MCG INHALER	28767
FLOVENT 100MCG DISKUS	53633
FLOVENT 250MCG DISKUS	53634
FLOVENT 50MCG DISKUS	53635
FLOVENT HFA 110 MCG INHALER	53636
FLOVENT HFA 220 MCG INHALER	53639
FLOVENT HFA 44 MCG INHALER	53638
FLUTICASONE PROP 100MCG DISKUS	53633
FLUTICASONE PROP 250MCG DISKUS	53634
FLUTICASONE PROP 50MCG DISKUS	53635
FLUTICASONE PROP HFA 110MCG	53636

Asthma Controller Medication	
Label Name	**GCN**
FLUTICASONE PROP HFA 220MCG	53639
FLUTICASONE PROP HFA 44MCG	53638
FLUTICASONE-SALMETEROL 55-14	42956
FLUTICASONE-SALMETEROL 113-14	42957
FLUTICASONE-SALMETEROL 232-14	42958
FLUTICASONE-VILANTEROL 100-25	34647
FLUTICASONE-VILANTEROL 200-25	35808
HYDROCORTISONE 20MG TABLET	26782
HYDROCORTISONE 5MG TABLET	26783
HYDROCORTONE 10MG TABLET	26781
MEDROL 16MG TABLET	27051
MEDROL 32MG TABLET	27055
MEDROL 4MG TABLET	27056
MEDROL 8MG TABLET	27058
METHYLPREDNISOLONE 16MG TABLET	27051
METHYLPREDNISOLONE 32MG TABLET	27055
METHYLPREDNISOLONE 4MG TABLET	27056
METHYLPREDNISOLONE 8MG TABLET	27058
MILLIPRED 5MG TABLET	26963
PREDNISOLONE 10MG/5ML SOLN	99610
PREDNISOLONE 15MG/5ML SOLN	26800
PREDNISOLONE 15MG/5ML SOLN	33806
PREDNISOLONE 20MG/5ML SOLN	14565
PREDNISOLONE 5MG/5ML SOLUTION	09115
PREDNISOLONE ODT 10MG TABLET	27108
PREDNISOLONE ODT 15MG TABLET	27109
PREDNISOLONE ODT 30MG TABLET	27114
PREDNISONE 10MG TABLET	27172
PREDNISONE 1MG TABLET	27171
PREDNISONE 2.5MG TABLET	27173
PREDNISONE 20MG TABLET	27174
PREDNISONE 5 MG TABLET	27176
PREDNISONE 50MG TABLET	27177
PREDNISONE 5MG/5ML SOLUTION	27160
PREDNISONE 5MG/5ML SOLUTION	27161
PULMICORT 0.25 MG/2 ML RESPULE	17957
PULMICORT 0.5MG/2ML RESPULE	17958

Asthma Controller Medication	
Label Name	**GCN**
PULMICORT 1 MG/2 ML RESPULE	62980
PULMICORT 180 MCG FLEXHALER	98025
PULMICORT 90 MCG FLEXHALER	98024
QVAR REDIHALER 40 MCG	43724
QVAR REDIHALER 80 MCG	43725
SYMBICORT 160-4.5 MCG INHALER	98500
SYMBICORT 80-4.5 MCG INHALER	98499
TRELEGY ELLIPTA 100-62.5-25	43921
TRELEGY ELLIPTA 200-62.5-25	48708
WIXELA 100-50 INHUB	50584
WIXELA 250-50 INHUB	50594
WIXELA 500-50 INHUB	50604

Moderate to Severe Asthma	
ICD-10 Code	**Description**
J4540	MODERATE PERSISTENT ASTHMA UNCOMPLICATED
J4541	MODERATE PERSISTENT ASTHMA WITH (ACUTE) EXACERBATION
J4542	MODERATE PERSISTENT ASTHMA WITH STATUS ASTHMATICUS
J4550	SEVERE PERSISTENT ASTHMA UNCOMPLICATED
J4551	SEVERE PERSISTENT ASTHMA WITH (ACUTE) EXACERBATION
J4552	SEVERE PERSISTENT ASTHMA WITH STATUS ASTHMATICUS
J82	PULMONARY EOSINOPHILIA, NOT ELSEWHERE CLASSIFIED

Moderate to Severe Persistent Asthma	
ICD-10 Code	**Description**
J4540	MODERATE PERSISTENT ASTHMA, UNCOMPLICATED
J4541	MODERATE PERSISTENT ASTHMA, WITH (ACUTE) EXACERBATION
J4542	MODERATE PERSISTENT ASTHMA, WITH STATUS ASTHMATICUS
J4550	SEVERE PERSISTENT ASTHMA, UNCOMPLICATED
J4551	SEVERE PERSISTENT ASTHMA, WITH (ACUTE) EXACERBATION
J4552	SEVERE PERSISTENT ASTHMA, WITH STATUS ASTHMATICUS

Severe Asthma	
ICD-10 Code	**Description**
J4550	SEVERE PERSISTENT ASTHMA, UNCOMPLICATED
J4551	SEVERE PERSISTENT ASTHMA, WITH (ACUTE) EXACERBATION

Severe Asthma	
ICD-10 Code	**Description**
J4552	SEVERE PERSISTENT ASTHMA, WITH STATUS ASTHMATICUS

Atopic Dermatitis	
ICD-10 Code	**Description**
L200	BESNIER'S PRURIGO
L2081	ATOPIC NEURODERMATITIS
L2082	FLEXURAL ECZEMA
L2084	INTRINSIC (ALLERGIC) ECZEMA
L2089	OTHER ATOPIC DERMATITIS
L209	ATOPIC DERMATITIS, UNSPECIFIED

Chronic Spontaneous Urticaria	
ICD-10 Code	**Description**
L500	ALLERGIC URTICARIA
L501	IDIOPATHIC URTICARIA
L508	OTHER (CHRONIC, RECURRENT) URTICARIA
L509	UNSPECIFIED URTICARIA

Chronic Obstructive Pulmonary Disease	
ICD-10 Code	**Description**
J440	CHRONIC OBSTRUCTIVE PULMONARY DISEASE WITH (ACUTE) LOWER RESPIRATORY INFECTION
J441	CHRONIC OBSTRUCTIVE PULMONARY DISEASE WITH (ACUTE) EXACERBATION
J4489	OTHER SPECIFIED CHRONIC OBSTRUCTIVE PULMONARY DISEASE
J449	CHRONIC OBSTRUCTIVE PULMONARY DISEASE, UNSPECIFIED

Crisaborole	
Label Name	**GCN**
EUCRISA 2% OINTMENT	42792

Crisaborole, Pimecrolimus or topical Tacrolimus	
Label Name	**GCN**
ELIDEL 1% CREAM	15348
EUCRISA 2% OINTMENT	42792
PIMECROLIMUS 1% CREAM	15348

Crisaborole, Pimecrolimus or topical Tacrolimus	
Label Name	**GCN**
PROTOPIC 0.03% OINTMENT	12289
PROTOPIC 0.1% OINTMENT	12302
TACROLIMUS 0.03% OINTMENT	12289
TACROLIMUS 0.1% OINTMENT	12302

Cyclophosphamide, Azathioprine, Methotrexate or Leflunomide	
Label Name	**GCN**
ARAVA 10MG TABLET	67031
ARAVA 20MG TABLET	67032
AZATHIOPRINE 50MG TABLET	46771
CYCLOPHOSPHAMIDE 25MG CAPSULE	35317
CYCLOPHOSPHAMIDE 50MG CAPSULE	35318
LEFLUNOMIDE 10MG TABLET	67031
LEFLUNOMIDE 20MG TABLET	67032
METHOTREXATE 2.5MG TABLET	38489
METHOTREXATE 50MG/2ML VIAL	18936
OTREXUP 10MG/0.4ML AUTO-INJ	35427
OTREXUP 15MG/0.4ML AUTO-INJ	35428
OTREXUP 20MG/0.4ML AUTO-INJ	35437
OTREXUP 25MG/0.4ML AUTO-INJ	35438
RASUVO 10MG/0.2ML AUTOINJ	36847
RASUVO 12.5MG/0.25ML AUTOINJ	36848
RASUVO 15MG/0.3ML AUTOINJ	36849
RASUVO 17.5MG/0.35ML AUTOINJ	36851
RASUVO 20MG/0.4ML AUTOINJ	35437
RASUVO 22.5MG/0.45ML AUTOINJ	36852
RASUVO 25MG/0.5ML AUTOINJ	36853
RASUVO 30MG/0.6ML AUTOINJ	36855
RASUVO 7.5MG/0.15ML AUTOINJ	36846
TREXALL 10MG TABLET	06484
TREXALL 15MG TABLET	13135
TREXALL 5MG TABLET	13134
TREXALL 7.5MG TABLET	38485
XATMEP 2.5MG/ML ORAL SOLUTION	43319

Duplicate Monoclonal Antibody Therapy	
Label Name	**GCN**
CINQAIR 100 MG/10 ML VIAL	40873
DUPIXENT 100 MG/0.67 ML SYRINGE	51385
DUPIXENT 200 MG/1.14 ML PEN	48785
DUPIXENT 200 MG/1.14 ML SYRINGE	45522
DUPIXENT 300 MG/2 ML PEN	48277
DUPIXENT 300 MG/2 ML SYRINGE	43222
FASENRA PEN 30 MG/ML	47019
NUCALA 100 MG/ML AUTO-INJECTOR	46414
NUCALA 100 MG/ML SYRINGE	46413
NUCALA 40 MG/0.4 ML SYRINGE	52416
TEZSPIRE 210 MG/1.91 ML PEN	53116

Eosinophilic Asthma	
ICD-10 Code	**Description**
J8283	EOSINOPHILIC ASTHMA

Eosinophilic Esophagitis	
ICD-10 Code	**Description**
K200	EOSINOPHILIC ESOPHAGITIS

Eosinophilic Granulomatosis with Polyangiitis	
ICD-10 Code	**Description**
M301	POLYARTERITIS WITH LUNG INVOLVEMENT [CHURG-STRAUSS]

Glucocorticoids, Oral	
Label Name	**GCN**
HYDROCORTISONE 20MG TABLET	26782
HYDROCORTISONE 5MG TABLET	26783
HYDROCORTONE 10MG TABLET	26781
MEDROL 16MG TABLET	27051
MEDROL 32MG TABLET	27055
MEDROL 4MG TABLET	27056
MEDROL 8MG TABLET	27058
METHYLPREDNISOLONE 16MG TABLET	27051
METHYLPREDNISOLONE 32MG TABLET	27055

Glucocorticoids, Oral	
Label Name	**GCN**
METHYLPREDNISOLONE 4MG TABLET	27056
METHYLPREDNISOLONE 8MG TABLET	27058
MILLIPRED 5MG TABLET	26963
PREDNISOLONE 10MG/5ML SOLN	99610
PREDNISOLONE 15MG/5ML SOLN	26800
PREDNISOLONE 15MG/5ML SOLN	33806
PREDNISOLONE 20MG/5ML SOLN	14565
PREDNISOLONE 5MG/5ML SOLUTION	09115
PREDNISOLONE ODT 10MG TABLET	27108
PREDNISOLONE ODT 15MG TABLET	27109
PREDNISOLONE ODT 30MG TABLET	27114
PREDNISONE 10MG TABLET	27172
PREDNISONE 1MG TABLET	27171
PREDNISONE 2.5MG TABLET	27173
PREDNISONE 20MG TABLET	27174
PREDNISONE 5 MG TABLET	27176
PREDNISONE 50MG TABLET	27177
PREDNISONE 5MG/5ML SOLUTION	27160
PREDNISONE 5MG/5ML SOLUTION	27161

H1 antihistamine	
Label Name	**GCN**
24HR ALLERGY (LEVOCETIRZN) 5 MG	14901
ALL DAY ALLERGY 10 MG TABLET	49291
ALLER-CHLOR 4MG TABLET	46512
ALLERGY (LORATADINE) 10 MG TAB	60563
ALLERGY 25 MG CAPSULE	45971
ALLERGY 4 MG TABLET	46512
ALLERGY RELIEF 10 MG TAB	60563
ALLERGY RELIEF 180 MG TABLET	46594
ALLERGY RELIEF 25 MG SOFTGEL	45971
ALLERGY RELIEF 25 MG TABLET	46071
ALLERGY RELIEF 4 MG TABLET	46512
ALLERGY RELIEF 5 MG/5 ML SOLN	60562
ALLERGY RELIEF D-12 TABLET	63570
ALLERGY RELIEF D-24HR TABLET	63577
ALLERGY RELIEF-D TABLET	13866

H1 antihistamine	
Label Name	**GCN**
ALLERGY RLF (CETRZN) 10 MG TAB	49291
ALLERGY-CONGEST 12HR 60-120 MG	63565
BANOPHEN 25 MG CAPSULE	45971
BANOPHEN 50 MG CAPSULE	45972
CETIRIZINE HCL 10 MG TABLET	49291
CETIRIZINE HCL 5 MG TABLET	49292
CETIRIZINE-PSE ER 5-120 MG TAB	13866
CHILD ALL DAY ALLERGY 1 MG/ML	49290
CHILD ALLERGY RELIEF 1 MG/ML	49290
CHILD ALLERGY RELIEF 5MG/5 ML	60562
CHILD ALLERGY RLF 12.5 MG/5 ML	48831
CHILD CETIRIZINE 10 MG CHEW TAB	21771
CHILD CETIRIZINE 5 MG CHEW TAB	21769
CHILD CETIRIZINE HCL 1 MG/ML SOL	49290
CHILD LORATADINE 5 MG/5 ML SOL	60562
CLARINEX 5 MG TABLET	12762
CLARINEX-D 12 HR 2.5-120 MG TAB	26558
CLEMASTINE FUM 2.68 MG TAB	46691
CYPROHEPTADINE 2 MG/5 ML SYRUP	15803
CYPROHEPTADINE 4 MG TABLET	15811
DESLORATADINE 2.5 MG ODT	25439
DESLORATADINE 5 MG ODT	19716
DESLORATADINE 5 MG TABLET	12762
DEXBROMPHENIR-PHENYLEPH 2-10 MG	28379
DIPHENHIST 25 MG CAPSULE	45971
DIPHENHYDRAMINE 12.5 MG/5 ML	48831
DIPHENHYDRAMINE 25 MG CAPSULE	45971
DIPHENHYDRAMINE 25 MG TABLET	46071
DIPHENHYDRAMINE 50 MG CAPSULE	45972
DIPHENHYDRAMINE 6.25 MG/ML	42545
FEXOFENADINE HCL 180 MG TABLET	46594
FEXOFENADINE HCL 60 MG TABLET	46593
FEXOFENADINE PSE ER 60-120 TAB	63565
GNP LORATADINE 10 MG TABLET	60563
GS ALLERGY RELIEF 10 MG TABLET	60563
HYDROXYZINE 10 MG/5 ML SYRUP	13932
HYDROXYZINE HCL 10 MG TABLET	13941
HYDROXYZINE HCL 25 MG TABLET	13943

H1 antihistamine	
Label Name	**GCN**
HYDROXYZINE HCL 50 MG TABLET	13944
HYDROXYZINE PAM 100 MG CAP	13951
HYDROXYZINE PAM 25 MG CAP	13952
HYDROXYZINE PAM 50 MG CAP	13953
LEVOCETIRIZINE 2.5 MG/5 ML SOL	97950
LEVOCETIRIZINE 5 MG TABLET	14901
LORATADINE 10 MG TABLET	60563
LORATADINE 5 MG/5 ML SYRUP	60562
LORATADINE ALLERGY 5 MG/5 ML	60562
LORATADINE-D 12 HOUR TABLET	63570
LORATADINE-D 24HR TABLET	63577
QC CHILD ALLERGY 12.5 MG/5 ML	48831
QC COMPLETE ALLERGY 25 MG CAP	45971
SILADRYL 12.5 MG/5 ML	48831
SM ALLERGY RELIEF 12.5 MG/5 ML	48831
SM LORATADINE 5 MG/5 ML SYRUUP	60562
SM LORATADINE D 24HR TABLET	63577
VISTARIL 25 MG CAPSULE	13952
VISTARIL 50 MG CAPSULE	13953

Helminth Infection	
ICD-10 Code	**Description**
B650	SCHISTOSOMIASIS DUE TO SCHISTOSOMA HAEMATOBIUM [URINARY SCHISTOSOMIASIS]
B651	SCHISTOSOMIASIS DUE TO SCHISTOSOMA MANSONI [INTESTINAL SCHISTOSOMIASIS]
B652	SCHISTOSOMIASIS DUE TO SCHISTOSOMA JAPONICUM
B653	CERCARIAL DERMATITIS
B658	OTHER SCHISTOSOMIASIS
B659	SCHISTOSOMIASIS, UNSPECIFIED
B660	OPISTHORCHIASIS
B661	CLONORCHIASIS
B662	DICROCELIASIS
B663	FASCIOLIASIS
B664	PARAGONIMIASIS
B665	FASCIOLOPSIASIS
B668	OTHER SPECIFIED FLUKE INFECTIONS
B669	FLUKE INFECTION, UNSPECIFIED

Helminth Infection	
ICD-10 Code	**Description**
B670	ECHINOCOCCUS GRANULOSUS INFECTION OF LIVER
B671	ECHINOCOCCUS GRANULOSUS INFECTION OF LUNG
B672	ECHINOCOCCUS GRANULOSUS INFECTION OF BONE
B6731	ECHINOCOCCUS GRANULOSUS INFECTION, THYROID GLAND
B6732	ECHINOCOCCUS GRANULOSUS INFECTION, MULTIPLE SITES
B6739	ECHINOCOCCUS GRANULOSUS INFECTION, OTHER SITES
B674	ECHINOCOCCUS GRANULOSUS INFECTION, UNSPECIFIED
B675	ECHINOCOCCUS MULTILOCULARIS INFECTION OF LIVER
B6761	ECHINOCOCCUS MULTILOCULARIS INFECTION, MULTIPLE SITES
B6769	ECHINOCOCCUS MULTILOCULARIS INFECTION, OTHER SITES
B677	ECHINOCOCCUS MULTILOCULARIS INFECTION, UNSPECIFIED
B678	ECHINOCOCCOSIS, UNSPECIFIED, OF LIVER
B6790	ECHINOCOCCOSIS, UNSPECIFIED
B6799	OTHER ECHINOCOCCOSIS
B680	TAENIA SOLIUM TAENIASIS
B681	TAENIA SAGINATA TAENIASIS
B689	TAENIASIS, UNSPECIFIED
B690	CYSTICERCOSIS OF CENTRAL NERVOUS SYSTEM
B691	CYSTICERCOSIS OF EYE
B6981	MYOSITIS IN CYSTICERCOSIS
B6989	CYSTICERCOSIS OF OTHER SITES
B699	CYSTICERCOSIS, UNSPECIFIED
B700	DIPHYLLOBOTHRIASIS
B701	SPARGANOSIS
B710	HYMENOLEPIASIS
B711	DIPYLIDIASIS
B718	OTHER SPECIFIED CESTODE INFECTIONS
B719	CESTODE INFECTION, UNSPECIFIED
B72	DRACUNCULIASIS
B7300	ONCHOCERCIASIS WITH EYE INVOLVEMENT, UNSPECIFIED
B7301	ONCHOCERCIASIS WITH ENDOPHTHALMITIS
B7302	ONCHOCERCIASIS WITH GLAUCOMA
B7309	ONCHOCERCIASIS WITH OTHER EYE INVOLVEMENT
B731	ONCHOCERCIASIS WITHOUT EYE DISEASE
B740	FILARIASIS DUE TO WUCHERERIA BANCROFTI
B741	FILARIASIS DUE TO BRUGIA MALAYI
B742	FILARIASIS DUE TO BRUGIA TIMORI

Helminth Infection	
ICD-10 Code	**Description**
B743	LOIASIS
B744	MANSONELLIASIS
B748	OTHER FILARIASES
B749	FILARIASIS, UNSPECIFIED
B75	TRICHINELLOSIS
B760	ANCYLOSTOMIASIS
B761	NECATORIASIS
B768	OTHER HOOKWORM DISEASES
B769	HOOKWORM DISEASE, UNSPECIFIED
B770	ASCARIASIS WITH INTESTINAL COMPLICATIONS
B7781	ASCARIASIS PNEUMONIA
B7789	ASCARIASIS WITH OTHER COMPLICATIONS
B779	ASCARIASIS, UNSPECIFIED
B780	INTESTINAL STRONGYLOIDIASIS
B781	CUTANEOUS STRONGYLOIDIASIS
B787	DISSEMINATED STRONGYLOIDIASIS
B789	STRONGYLOIDIASIS, UNSPECIFIED
B79	TRICHURIASIS
B80	ENTEROBIASIS
B810	ANISAKIASIS
B811	INTESTINAL CAPILLARIASIS
B812	TRICHOSTRONGYLIASIS
B813	INTESTINAL ANGIOSTRONGYLIASIS
B814	MIXED INTESTINAL HELMINTHIASES
B818	OTHER SPECIFIED INTESTINAL HELMINTHIASES
B820	INTESTINAL HELMINTHIASIS, UNSPECIFIED
B829	INTESTINAL PARASITISM, UNSPECIFIED
B830	VISCERAL LARVA MIGRANS
B831	GNATHOSTOMIASIS
B832	ANGIOSTRONGYLIASIS DUE TO PARASTRONGYLUS CANTONENSIS
B833	SYNGAMIASIS
B834	INTERNAL HIRUDINIASIS
B838	OTHER SPECIFIED HELMINTHIASES
B839	HELMINTHIASIS, UNSPECIFIED

Hypereosinophilic Syndrome	
ICD-10 Code	**Description**
D72110	IDIOPATHIC HYPEREOSINOPHILIC SYNDROME (IHES)
D72111	LYMPHOCYTIC VARIANT HYPEREOSINOPHILIC SYNDROME (LHES)
D72118	OTHER HYPEREOSINOPHILIC SYNDROME
D72119	HYPEREOSINOPHILIC SYNDROME (HES), UNSPECIFIED

IgE-mediated food allergy	
ICD-10 Code	**Description**
Z91010	ALLERGY TO PEANUTS
Z91011	ALLERGY TO MILK PRODUCTS
Z91012	ALLERGY TO EGGS
Z91013	ALLERGY TO SEAFOOD
Z91014	ALLERGY TO MAMMALIAN MEATS
Z91018	ALLERGY TO OTHER FOODS

Inhaled corticosteroid (ICS)	
Label Name	**GCN**
ADVAIR 100-50 DISKUS	50584
ADVAIR 250-50 DISKUS	50594
ADVAIR 500-50 DISKUS	50604
ADVAIR HFA 115-21MCG INHALER	97136
ADVAIR HFA 230-21MCG INHALER	97137
ADVAIR HFA 45-21MCG INHALER	97135
AIRDUO DIGIHALER 113-14MCG	48494
AIRDUO DIGIHALER 232-14MCG	48495
AIRDUO DIGIHALER 55-14MCG	48489
AIRSUPRA 90-80MCG INHALER	53534
ALVESCO 160 MCG INHALER	24152
ALVESCO 80 MCG INHALER	24149
ARMONAIR RESPICLICK 232MCG	42985
ARMONAIR RESPICLICK 55MCG	42979
ARMONAIR DIGIHALER 55MCG	48602
ARMONAIR DIGIHALER 113 MCG	48604
ARMONAIR DIGIHALER 232 MCG	48615
ARNUITY ELLIPTA 100 MCG INH	37007
ARNUITY ELLIPTA 200 MCG INH	37008
ARNUITY ELLIPTA 50 MCG INH	44783

Inhaled corticosteroid (ICS)	
Label Name	**GCN**
ASMANEX HFA 100 MCG INHALER	37566
ASMANEX HFA 200 MCG INHALER	37565
ASMANEX HFA 50 MCG INHALER	47599
ASMANEX TWISTHALER 220 MCG #14	24927
ASMANEX TWISTHALER 110 MCG #30	99721
ASMANEX TWISTHALER 220 MCG #30	24928
ASMANEX TWISTHALER 220 MCG #60	24929
ASMANEX TWISTHALR 220 MCG #120	18987
BREO ELLIPTA 100-25MCG INH	34647
BREO ELLIPTA 200-25MCG INHALER	35808
BREYNA 160-4.5MCG INHALER	98500
BREYNA 80-4.5MCG INHALER	98499
BREZTRI AEROSPHERE INHALER	48435
BUDESONIDE 0.25MG/2ML INHALATION SUSPENSION	17957
BUDESONIDE 0.5MG/2ML INHALATION SUSPENSION	17958
BUDESONIDE 1MG/2ML INHALATION SUSPENSION	62980
DULERA 100 MCG/5 MCG INHALER	28766
DULERA 200 MCG/5 MCG INHALER	28767
DULERA 50 MCG/5 MCG INHALER	30139
FLOVENT 100MCG DISKUS	53633
FLOVENT 250MCG DISKUS	53634
FLOVENT 50MCG DISKUS	53635
FLOVENT HFA 110 MCG INHALER	53636
FLOVENT HFA 220 MCG INHALER	53639
FLOVENT HFA 44 MCG INHALER	53638
FLUTICASONE PROP 100MCG DISKUS	53633
FLUTICASONE PROP 250MCG DISKUS	53634
FLUTICASONE PROP 50MCG DISKUS	53635
FLUTICASONE PROP HFA 110MCG	53636
FLUTICASONE PROP HFA 220MCG	53639
FLUTICASONE PROP HFA 44MCG	53638
FLUTICASONE-SALMETEROL 55-14	42956
FLUTICASONE-SALMETEROL 113-14	42957
FLUTICASONE-SALMETEROL 232-14	42958
FLUTICASONE-VILANTEROL 100-25	34647
FLUTICASONE-VILANTEROL 200-25	35808
PULMICORT 0.25 MG/2 ML RESPULE	17957
PULMICORT 0.5MG/2ML RESPULE	17958

Inhaled corticosteroid (ICS)	
Label Name	**GCN**
PULMICORT 1 MG/2 ML RESPULE	62980
PULMICORT 180 MCG FLEXHALER	98025
PULMICORT 90 MCG FLEXHALER	98024
QVAR REDIHALER 40 MCG	43724
QVAR REDIHALER 80 MCG	43725
SYMBICORT 160-4.5 MCG INHALER	98500
SYMBICORT 80-4.5 MCG INHALER	98499
TRELEGY ELLIPTA 100-62.5-25	43921
TRELEGY ELLIPTA 200-62.5-25	48708
WIXELA 100-50 INHUB	50584
WIXELA 250-50 INHUB	50594
WIXELA 500-50 INHUB	50604

Intranasal Corticosteroid (INC)	
Label Name	**GCN**
AZELASTIN-FLUTIC 137-50 MCG SPR	32099
BECONASE AQ 0.042% SPRAY	47100
BUDESONIDE 32MCG NASAL SPRAY	92231
DYMISTA NASAL SPRAY	32099
FLUNISOLIDE 0.025% SPRAY	34280
FLUTICASONE PROP 50MCG SPRAY	62263
MOMETASONE FUROATE 50MGCG SPRY	71431
OMNARIS 50 MCG NASAL SPRAY	97453
QNASL CHILDRENS 40MCG SPRAY	37654
QNASL 80MCG NASAL SPRAY	31769
RYALTRIS 665-25MCG SPRAY	49205
TRIAMCINOLONE 55MCG NASAL SPRAY	36145
XHANCE 93MCG NASAL SPRAY	43878

LABA, LTM, LAMA or theophylline	
Label Name	**GCN**
MONTELUKAST SOD 10MG TABLET	94444
MONTELUKAST SOD 4MG GRANULES	18803
MONTELUKAST SOD 4MG TAB CHEW	42373
MONTELUKAST SOD 5MG TAB CHEW	94440
SEREVENT DISKUS 50MCG	64012
SINGULAIR 10MG TABLET	94444

LABA, LTM, LAMA or theophylline	
Label Name	**GCN**
SINGULAIR 4MG GRANULES	18803
SINGULAIR 4MG TABLET CHEW	42373
SINGULAIR 5MG TABLET CHEW	94440
SPIRIVA 18 MCG CP-HANDIHALER	17853
SPIRIVA RESPIMAT 1.25 MCG INH	39587
SPIRIVA RESPIMAT 2.5 MCG INH	98921
THEO-24 ER 100 MG CAPSULE	00324
THEO-24 ER 200 MG CAPSULE	00325
THEO-24 ER 300 MG CAPSULE	00326
THEO-24 ER 400 MG CAPSULE	00323
THEOPHYLLINE 80 MG/15 ML SOLN	01080
THEOPHYLLINE ER 300 MG TAB	00413
THEOPHYLLINE ER 400 MG TABLET	00415
THEOPHYLLINE ER 450 MG TAB	00416
THEOPHYLLINE ER 600 MG TABLET	00417
TRELEGY ELLIPTA 100-62.5-25	43921
TRELEGY ELLIPTA 200-62.5-25	48708
ZAFIRLUKAST 10MG TABLET	52271
ZAFIRLUKAST 20MG TABLET	18690
ZILEUTON ER 600MG TABLET	98822
ZYFLO CR 600MG TABLET	98822

Nasal Polyps	
ICD-10 Code	**Description**
J330	POLYP OF NASAL CAVITY
J331	POLYPOID SINUS DEGENERATION
J338	OTHER POLYP OF SINUS
J339	NASAL POLYP, UNSPECIFIED

Prurigo Nodularis	
ICD-10 Code	**Description**
L281	PRURIGO NODULARIS

Topical Corticosteroid	
Label Name	**GCN**
AMCINONIDE 0.1% CREAM	31490
AMCINONIDE 0.1% LOTION	31560

Topical Corticosteroid	
Label Name	**GCN**
APEXICON E 0.05% CREAM	67730
BETAMETHASONE DP 0.05% CRM	31060
BETAMETHASONE DP 0.05% LOT	31080
BETAMETHASONE DP 0.05% OINT	31070
BETAMETHASONE DP AUG 0.05% CRM	31890
BETAMETHASONE DP AUG 0.05% GEL	32091
BETAMETHASONE DP AUG 0.05% LOT	30980
BETAMETHASONE DP AUG 0.05% OIN	31910
BETAMETHASONE VA 0.1% CREAM	31101
BETAMETHASONE VALER 0.12% FOAM	32052
BETAMETHASONE VA 0.1% LOTION	31120
BETAMETHASONE VALER 0.1% OINTM	31110
BETA-VAL 0.1% LOTION	31120
CLOBETASOL 0.05% CREAM	32140
CLOBETASOL 0.05% GEL	15892
CLOBETASOL 0.05% OINTMENT	32130
CLOBETASOL 0.05% SOLUTION	15891
CLOBETASOL EMOLLIENT 0.05% CRM	34141
CLOBETASOL PROP 0.05% FOAM	89743
CLOBEX 0.05% SPRAY	25909
CLOBEX 0.05% TOPICAL LOTION	34040
CORMAX 0.05% SOLUTION	15891
DESOXIMETASONE 0.05% CREAM	31180
DESOXIMETASONE 0.05% GEL	06120
DESOXIMETASONE 0.25% CREAM	31181
DESOXIMETASONE 0.25% OINTMENT	30800
DIFLORASONE 0.05% CREAM	31470
DIFLORASONE 0.05% OINTMENT	31480
DIPROLENE 0.05% LOTION	30980
DIPROLENE AF 0.05% CREAM	31890
DIPROLENE 0.05% OINTMENT	31910
DIPROLENE AF 0.05% CREAM	31890
FLUOCINONIDE 0.05% CREAM	31390
FLUOCINONIDE 0.05% GEL	31380
FLUOCINONIDE 0.05% OINTMENT	31400
FLUOCINONIDE 0.05% SOLUTION	31401
FLUOCINONIDE-E 0.05% CREAM	54650

Topical Corticosteroid	
Label Name	**GCN**
FLUOCINONIDE-EMOL 0.05% CREAM	54650
FLUOCINONIDE 0.1% CREAM	24306
HALOBETASOL PROP 0.05% CREAM	31251
HALOBETASOL PROP 0.05% OINTMNT	31211
HALOG 0.1% CREAM	31441
HALOG 0.1% OINTMENT	31451
OLUX 0.05% FOAM	89743
OLUX-E 0.05% FOAM	97649
SERNIVO 0.05% SPRAY	40655
TEMOVATE 0.05% CREAM	32140
TEMOVATE 0.05% OINTMENT	32130
TOPICORT 0.05% GEL	06120
TOPICORT 0.25% CREAM	31181
TOPICORT 0.25% OINTMENT	30800
TOPICORT LP 0.05% CREAM	31180
TOPICORT 0.25% SPRAY	34545
TRIAMCINOLONE 0.025% CREAM	31231
TRIAMCINOLONE 0.025% LOTION	31260
TRIAMCINOLONE 0.025% OINT	31241
TRIAMCINOLONE 0.1% CREAM	31232
TRIAMCINOLONE 0.1% LOTION	31261
TRIAMCINOLONE 0.1% OINTMENT	31242
TRIAMCINOLONE 0.5% CREAM	31233
TRIAMCINOLONE 0.5% OINTMENT	31244
TRIANEX 0.05% OINTMENT	31243
ULTRAVATE 0.05% CREAM	31251
VANOS 0.1% CREAM	24306

Xolair – IgE-mediated Food Allergy Dosing														
Pretreatment Serum Ige (IU/mL)	Dosing Frequency	Body Weight (kg)												
		≥10-12	>12-15	>15-20	>20-25	>25-30	>30-40	>40-50	>50-60	>60-70	>70-80	>80-90	>90-125	>125-150
		Dose (mg)												
≥30-100	Every 4 weeks	75	75	75	75	75	75	150	150	150	150	150	300	300
>100-200		75	75	75	150	150	150	300	300	300	300	300	450	600
>200-300		75	75	150	150	150	225	300	300	450	450	450	600	375
>300-400		150	150	150	225	225	300	450	450	450	600	600	450	525
>400-500		150	150	225	225	300	450	450	600	600	375	375	525	600
>500-600		150	150	225	300	300	450	600	600	375	450	450	600	
>600-700		150	150	225	300	225	450	600	375	450	450	525		

>700-800	Every 2 weeks	150	150	150	225	225	300	375	450	450	525	600
>800-900		150	150	150	225	225	300	375	450	525	600	
>900-1000		150	150	225	225	300	375	450	525	600		
>1000-1100		150	150	225	225	300	375	450	600			
>1100-1200		150	150	225	300	300	450	525	600			
>1200-1300		150	225	225	300	375	450	525				
>1300-1500		150	225	300	300	375	525	600				
>1500-1850			225	300	375	450	600					

Xolair - Asthma Dosing for Patients 12 years and older					
Pretreatment Serum Ige (IU/mL)	Dosing Frequency	30-60 kg	>60-70kg	>70-90 kg	>90-150 kg
		Dose (mg)			
≥30-100	Every 4 weeks	150	150	150	300
>100-200		300	300	300	225
>200-300		300	225	225	300
>300-400	Every 2 weeks	225	225	300	
>400-500		300	300	375	
>500-600		300	375		
>600-700		375			

Xolair - Asthma Dosing for Patients 6 to < 12 years of age											
Pretreatment Serum Ige (IU/mL)	Dosing Frequency	20-25kg	>25-30kg	>30-40kg	>40-50kg	>50-60kg	>60-70kg	>70-80kg	>80-90kg	>90-125kg	>125-150kg
		Dose (mg)									
≥30-100	Every 4 weeks	75	75	75	150	150	150	150	150	300	300
>100-200		150	150	150	300	300	300	300	300	225	300
>200-300		150	150	225	300	300	225	225	225	300	375
>300-400		225	225	300	225	225	225	300	300		
>400-500		225	300	225	225	300	300	375	375		
>500-600		300	300	225	300	300	375				
>600-700		300	225	225	300	375					
>700-800	Every 2 weeks	225	225	300	375						
>800-900		225	225	300	375						
>900-1000		225	300	375							
>1000-1100		225	300	375							
>1100-1200		300	300								
>1200-1300		300	375								

Xolair - Nasal Polyp Dosing									
Pretreatment Serum Ige (IU/mL)	Dosing Frequency	>30-40kg	>40-50kg	>50-60kg	>60-70kg	>70-80kg	>80-90kg	>90-125kg	>125-150kg
		Dose (mg)							
≥30-100	Every 4 weeks	75	150	150	150	150	150	300	300
>100-200		150	300	300	300	300	300	450	600
>200-300		225	300	300	450	450	450	600	375
>300-400		300	450	450	450	600	600	450	525
>400-500		450	450	600	600	375	375	525	600
>500-600		450	600	600	375	450	450	600	
>600-700		450	600	375	450	450	525		
>700-800	Every 2 weeks	300	375	450	450	525	600		
>800-900		300	375	450	525	600			
>900-1000		375	450	525	600				
>1000-1100		375	450	600					
>1100-1200		450	525	600					
>1200-1300		450	525						
>1300-1500		525	600						

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Monoclonal Antibody Agents

Clinical Criteria References

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9. Fasenra (benralizumab) [prescribing information]. Wilmington, DE: AstraZeneca Pharmaceuticals LP; September 2024.

10. Nucala (mepolizumab) [prescribing information]. Philadelphia, PA: GlaxoSmithKline LLC; March 2023.

11. Tezspire (Tezepelumab-ekko) [prescribing information]. Thousand Oaks, CA: AstraZeneca; May 2023.

12. Ebglyss Prescribing Information. Indianapolis, IN. Eli Lilly and Company. November 2024.

Publication History

The Publication History records the publication iterations and revisions to this document. Notes for the *most current revision* are also provided in the **Revision Notes** on the first page of this document.

Publication Date	Notes
04/24/2020	Initial publication and presentation to DUR Board
05/26/2020	Removed GCN for Fasenra syringe
02/01/2021	Updated Fasenra criteria: • Updated lookback to 180 days in question #6 on criteria logic and logic diagram • Clarified question #7 and #8 – added greater than 1 syringe or pen per 56 days is equivalent to 0.018 units/day and greater than 1 syringe or pen per 28 days is equivalent to 0.036 units/day on criteria logic and logic diagram Updated Nucala criteria: • Added diagnosis of hypereosinophilic syndrome (HES) and age check to criteria logic and logic diagram • Added HES diagnosis table Updated references
06/08/2021	Updated Nucala criteria: • Removed approval criteria for clients aged 6-11 years; prescribing information states that prefilled autoinjector and prefilled syringe are only for use in adults and adolescents ages 12 and older
08/09/2021	Updated Nucala criteria: • Added diagnosis of chronic rhinosinusitis with nasal polyps for clients ≥ 18 years of age that had an inadequate response to intranasal corticosteroids
04/27/2022	Combined Dupixent clinical criteria guide with Monoclonal Antibody clinical criteria guide Added criteria for Adbry as approved by the DUR Board
	Added GCN for Dupixent (51385) to PA table Added diagnosis of eosinophilic esophagitis for clients ≥ 12 years of age for Dupixent
06/09/2022	Updated age to ≥ 6 months for Dupixent for patients with atopic dermatitis
06/13/2022	Updated age to ≥ 6 years for Nucala for patients with asthma
07/25/2022	Added criteria for Xolair as approved by the DUR Board on July 22, 2022

Publication Date	Notes
08/10/2022	Added pimecrolimus and tacrolimus (topical) as prior therapy for Dupixent when using to treat atopic dermatitis
10/28/2022	Added diagnosis of prurigo nodularis for clients ≥ 18 years of age for Dupixent Removed ICD-10 codes for unspecified asthma
03/23/2023	Updated Nucala criteria: Added diagnosis of chronic rhinosinusitis with nasal polyps for clients ≥ 18 years of age that had an inadequate response to intranasal corticosteroids Updated Dupixent criteria: Updated age to ≥ 6 months for clients with atopic dermatitis Removed ICD-10 codes for unspecified asthma Updated references
01/10/2024	Annual review by staff Added GCNs for AirDuo (48494, 48495, 48489), Armonair (42985, 42979, 48602, 48604, 48615), Asmanex (47599, 37566, 37565), Breyna (98500, 98499), budesonide-formoterol (98500, 98499), fluticasone diskus (53633, 53634, 53635), fluticasone HFA (53639, 53636, 53638), fluticasone-vilanterol (34647, 35808), Ryaltris (49205) Removed GCNs for Beconase AQ (47100) and Nasonex (71431) - products have been discontinued Updated references
01/19/2024	Updated age for Adbry to 12 years and older
02/06/2024	Dupixent – updated age for eosinophilic esophagitis to 1 year and older with weight greater than or equal to 15 kg
03/12/2024	Dupixent – updated step 4 (Is the client ≥ 6 years of age?); from 'if no, deny' to 'no, go to step 7'
04/02/2024	Xolair – added diagnosis of IgE-mediated food allergy for clients 1 year and older
05/07/2024	Fasenra – added indication for eosinophilic asthma and updated age to ≥ 6 years of age
05/09/2024	Added GCN for Nucala (52416) to Drugs Requiring PA table and to the Duplicate Monoclonal Antibody Therapy table
05/14/2024	Added GCN for Fasenra (55559) to Drugs Requiring PA table and to the Duplicate Monoclonal Antibody Therapy table
08/13/2024	Annual review by staff Updated age for Adbry 150mg/mL syringe to 12 and older Added GCN for Adbry (55922) to drugs requiring PA Added GCN for Airsupra (53534), Beconase AQ (47100), Breztri (48435), and Trelegy Ellipta (43921, 48708) Updated references
09/19/2024	Removed GCN for Fasenra (55559) – product is for healthcare provider administration only

Publication Date	Notes
10/01/2024	Dupixent: Updated age to ≥ 12 years for the diagnosis of chronic rhinosinusitis with nasal polyps and added a diagnosis of COPD for adults Fasenra: Added a diagnosis of EGPA for adults
11/07/2024	Added criteria for Tezspire
01/07/2025	Added GCNs for Xolair (55222, 55223, 55224, 55225) to Drugs Requiring PA Table
01/31/2025	Added criteria for Ebglyss as approved by the DURB Board

