

Texas Prior Authorization Program
Clinical Criteria

Drug/Drug Class

Monoclonal Antibody Agents

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

Clinical Criteria 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

Dupixent (Dupilumab)

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Ebglyss (Ibrikizumab-Ibkz)

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Fasenra (Benralizumab)

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Nucala (Mepolizumab)

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Tezspire (Tezepelumab-ekko)

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Xolair (Omalizumab)

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Note: Click the hyperlink to navigate directly to that section.

Revision Notes

Updated the max quantity check for clients using Fasentra for eosinophilic granulomatosis with polyangiitis (EGPA)



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/searches/formulary-drug-search.

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

**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 (\geq) 12 years of age?
 Yes – Go to #5
 No – Deny
4. Is the client greater than or equal to (\geq) 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 (\geq) 10% of the client's body surface area?
 Yes – Go to #6
 No – Deny
6. Does the client have a claim for a [topical corticosteroid](#) and either [crisaborole](#), [pimecrolimus](#), or [topical tacrolimus](#) 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:

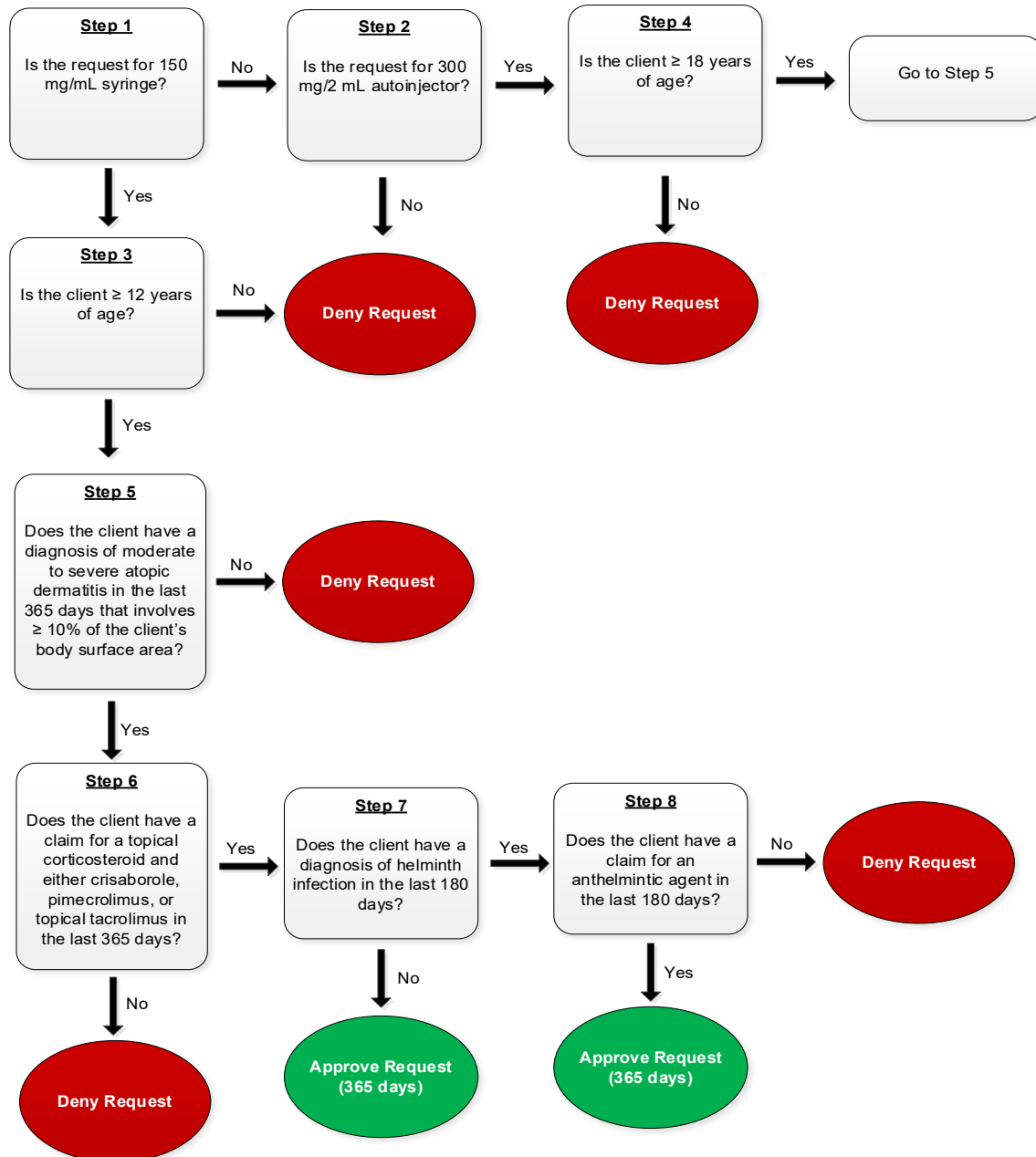
1. Does the client have a [diagnosis of atopic dermatitis](#) in past medical and/or pharmacy claims history?
 Yes – Go to #2
 No – Deny
2. Does the client have a [diagnosis of helminth infection](#) in the last 180 days?
 Yes – Go to #3
 No – Go to #4
3. Does the client have a claim for an [anthelmintic agent](#) in the last 180 days?
 Yes – Go to #4
 No – Deny
4. Does the client continue to show improvement?
 Yes – Approve (365 days)
 No – Deny



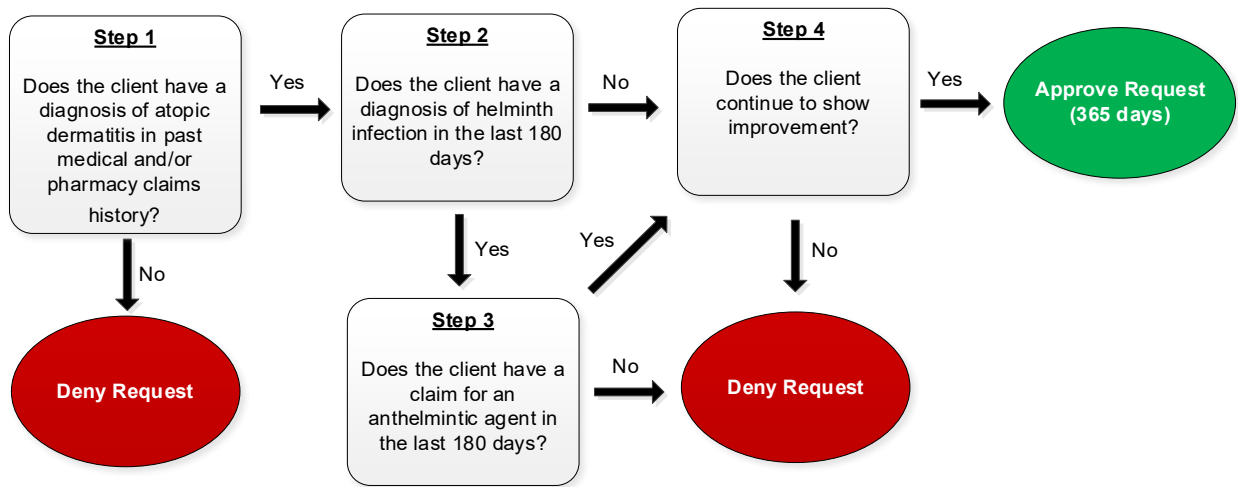
Adbry (Tralokinumab-ldrm)

Clinical Criteria Logic Diagram

Initial Requests:



Renewal Requests:





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

**Dupixent (Dupilumab)****Clinical Criteria Logic**

Initial Requests:

1. Is the client greater than or equal to (\geq) 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 (\geq) 10% of the client's body surface area?
 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 (\geq) 6 years of age?
 Yes – Go to #5
 No – Go to #8
5. Does the client have a [diagnosis of moderate-to-severe asthma](#) in past medical and/or pharmacy claims history?
 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 #8
7. Does the client have a [diagnosis of allergic fungal rhinosinusitis \(AFRS\)](#) in past medical and/or pharmacy claims history?
 Yes – Approve (365 days)
 No – Go to #8
8. Is the client greater than or equal to (\geq) 1 year of age?
 Yes – Go to #9

- No – Go to #11
9. Does the client have a [diagnosis of eosinophilic esophagitis](#) in past medical and/or pharmacy claims history?
- Yes – Go to #10
- No – Go to #11
10. Does the client weigh greater than or equal to (\geq) 15 kg?
- Yes – Approve (365 days)
- No – Go to #11
11. Is the client greater than or equal to (\geq) 12 years of age?
- Yes – Go to #12
- No – Deny
12. Does the client have a [diagnosis of chronic rhinosinusitis with nasal polyps](#) in past medical and/or pharmacy claims history?
- Yes – Go to #13
- No – Go to #14
13. 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 #17
14. Does the client have a [diagnosis of chronic spontaneous urticaria \(CSU\)](#) in past medical and/or pharmacy claims history?
- Yes – Go to #15
- No – Go to #17
15. Does the client have a claim for a [H1 antihistamine](#) in the last 90 days?
- Yes – Approve (365 days)
- No – Go to #16
16. Does the client have an intolerance or a contraindication to H1 antihistamines?
- Yes – Approve (365 days)
- No – Deny
17. Is the client greater than or equal to (\geq) 18 years of age?
- Yes – Go to #18
- No – Deny

18. Does the client have a diagnosis of [bullous pemphigoid \(BP\)](#), [prurigo nodularis](#), or [chronic obstructive pulmonary disease \(COPD\)](#) in past medical and/or pharmacy claims history?

Yes – Approve (365 days)

No – Deny

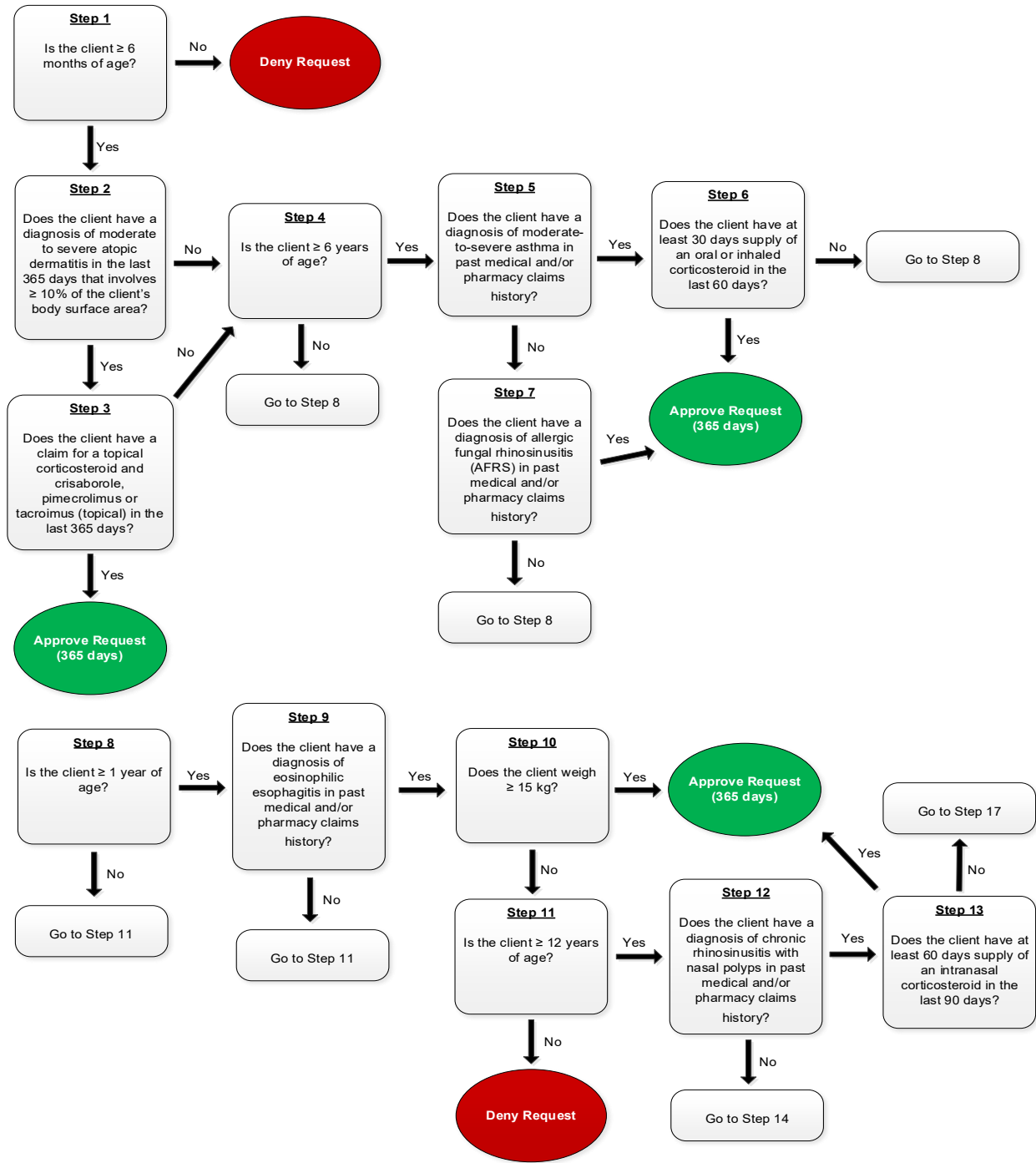
Renewal Requests:

1. Does the client have a diagnosis of [allergic fungal rhinosinusitis \(AFRS\)](#), [atopic dermatitis](#), [asthma](#), [bullous pemphigoid](#), [chronic obstructive pulmonary disease \(COPD\)](#), [chronic rhinosinusitis with nasal polyps](#), [chronic spontaneous urticaria \(CSU\)](#), [eosinophilic esophagitis](#), or [prurigo nodularis](#) in past medical and/or pharmacy claims history?
 Yes – Go to #2
 No – Deny
2. Does the client continue to show improvement?
 Yes – Approve (365 days)
 No – Deny

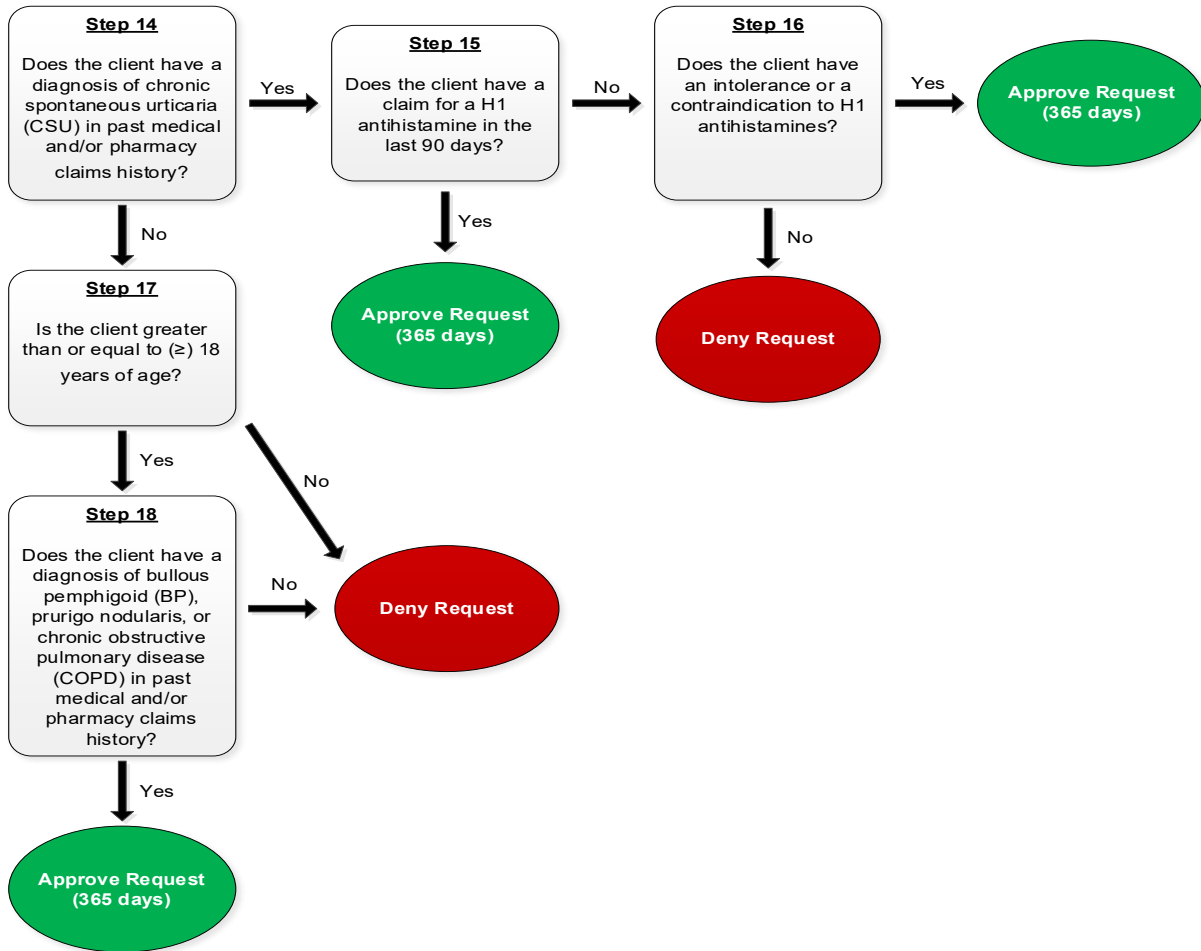


Dupixent (Dupilumab) Clinical Criteria Logic Diagram

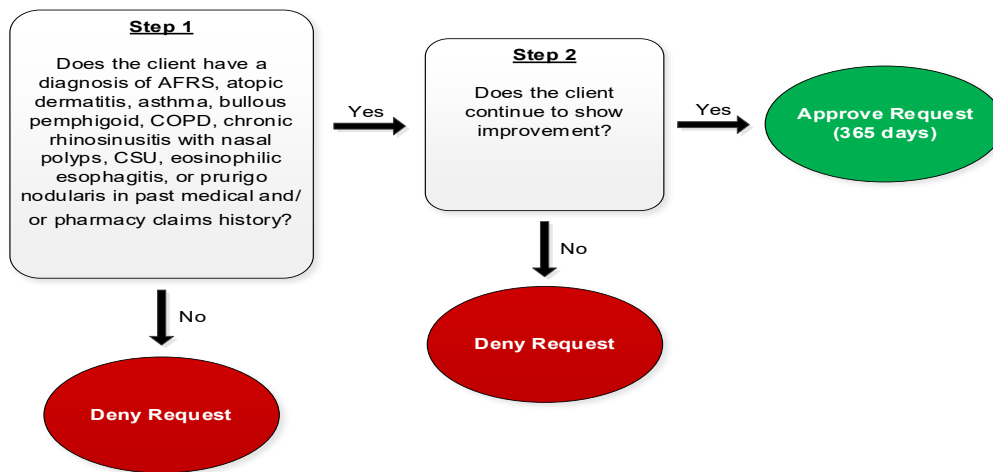
Initial Requests:



Initial Requests, Continued:



Renewal Requests:



**Ebglyss (lebrikizumab-lbkz)**
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/searches/formulary-drug-search.

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

**Ebglyss (lebrikizumab-lbkz)****Clinical Criteria Logic**

Initial Requests:

1. Is the client greater than or equal to (\geq) 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 (\geq) 10% of the client's body surface area?
 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:

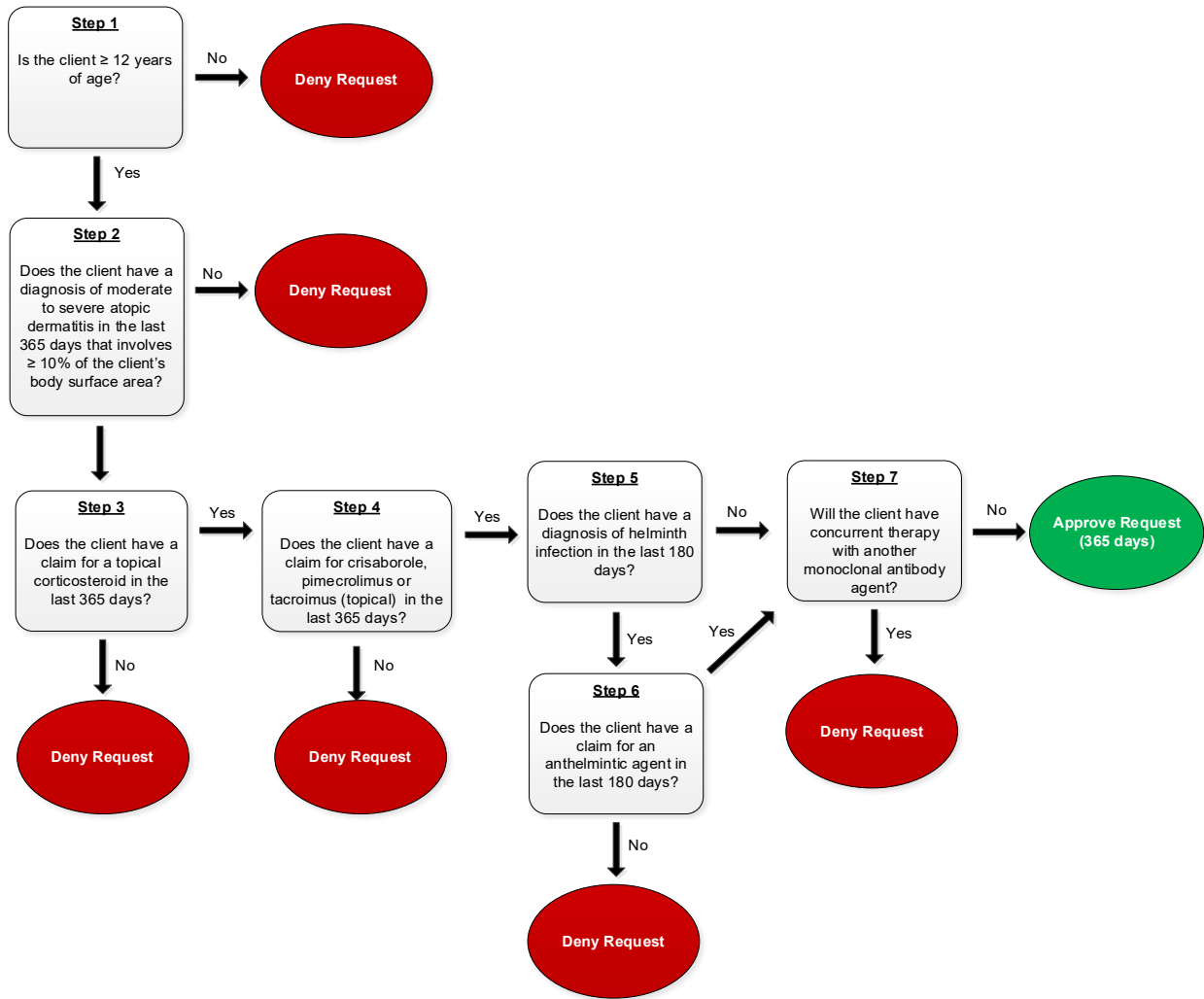
1. Does the client have a [diagnosis of helminth infection](#) in the last 180 days?
 Yes – Go to #2
 No – Go to #3
2. Does the client have a claim for an [anthelmintic agent](#) in the last 180 days?
 Yes – Go to #3
 No – Deny
3. Will the client have concurrent therapy with another [monoclonal antibody agent](#)?
 Yes – Deny
 No – Go to #4
4. Does the client continue to show improvement or stabilization?
 Yes – Approve (365 days)
 No – Deny



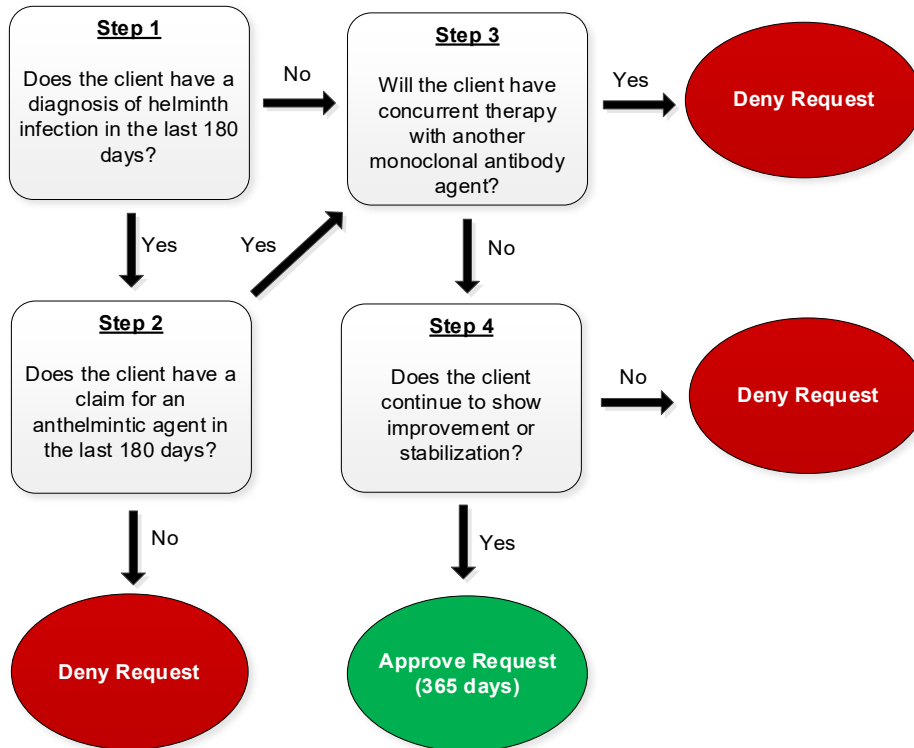
Ebglyss (lebrikizumab-lbkz)

Clinical Criteria Logic Diagram

Initial Requests:



Renewal Requests:





Fasenra (Benralizumab)

Drugs Requiring Prior Authorization

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

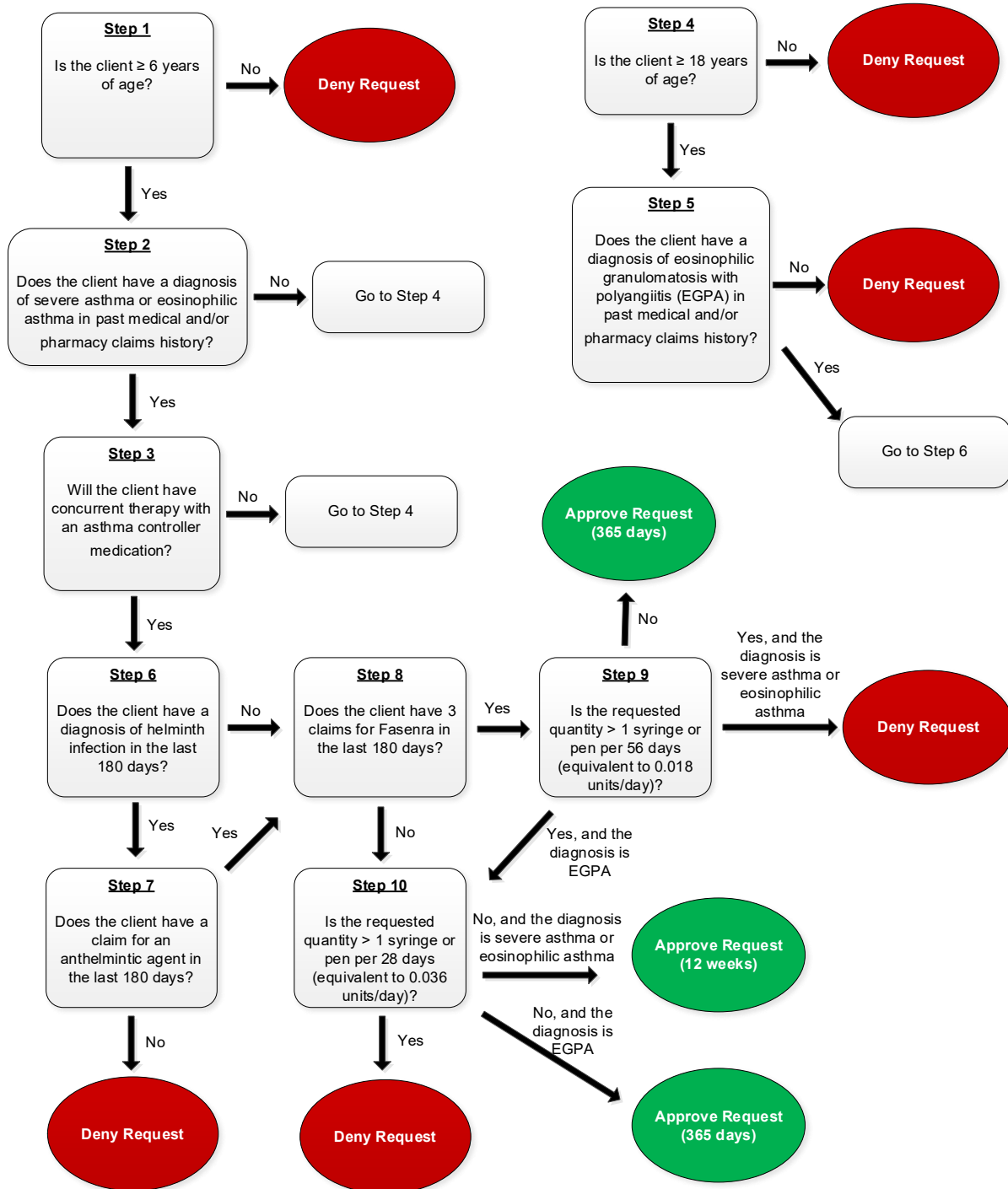
**Fasenra (Benralizumab)****Clinical Criteria Logic**

1. Is the client greater than or equal to (\geq) 6 years of age?
 Yes – Go to #2
 No – Deny
2. Does the client have a diagnosis of [severe asthma](#) or [eosinophilic asthma](#) in past medical and/or pharmacy claims history?
 Yes – Go to #3
 No – Go to #4
3. Will the client have concurrent therapy with an [asthma controller medication](#)?
 Yes – Go to #6
 No – Go to #4
4. Is the client greater than or equal to (\geq) 18 years of age?
 Yes – Go to #5
 No – Deny
5. Does the client have a [diagnosis of eosinophilic granulomatosis with polyangiitis \(EGPA\)](#) in past medical and/or pharmacy claims history?
 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 (And the diagnosis is severe asthma or eosinophilic asthma) – Deny

- Yes (And the diagnosis is EGPA) – Go to #10
 - 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 (And the diagnosis is severe asthma or eosinophilic asthma) – Approve (12 weeks)
 - No (And the diagnosis is EGPA) – Approve (365 days)



Fasenra (Benralizumab) Clinical Criteria Logic Diagram





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

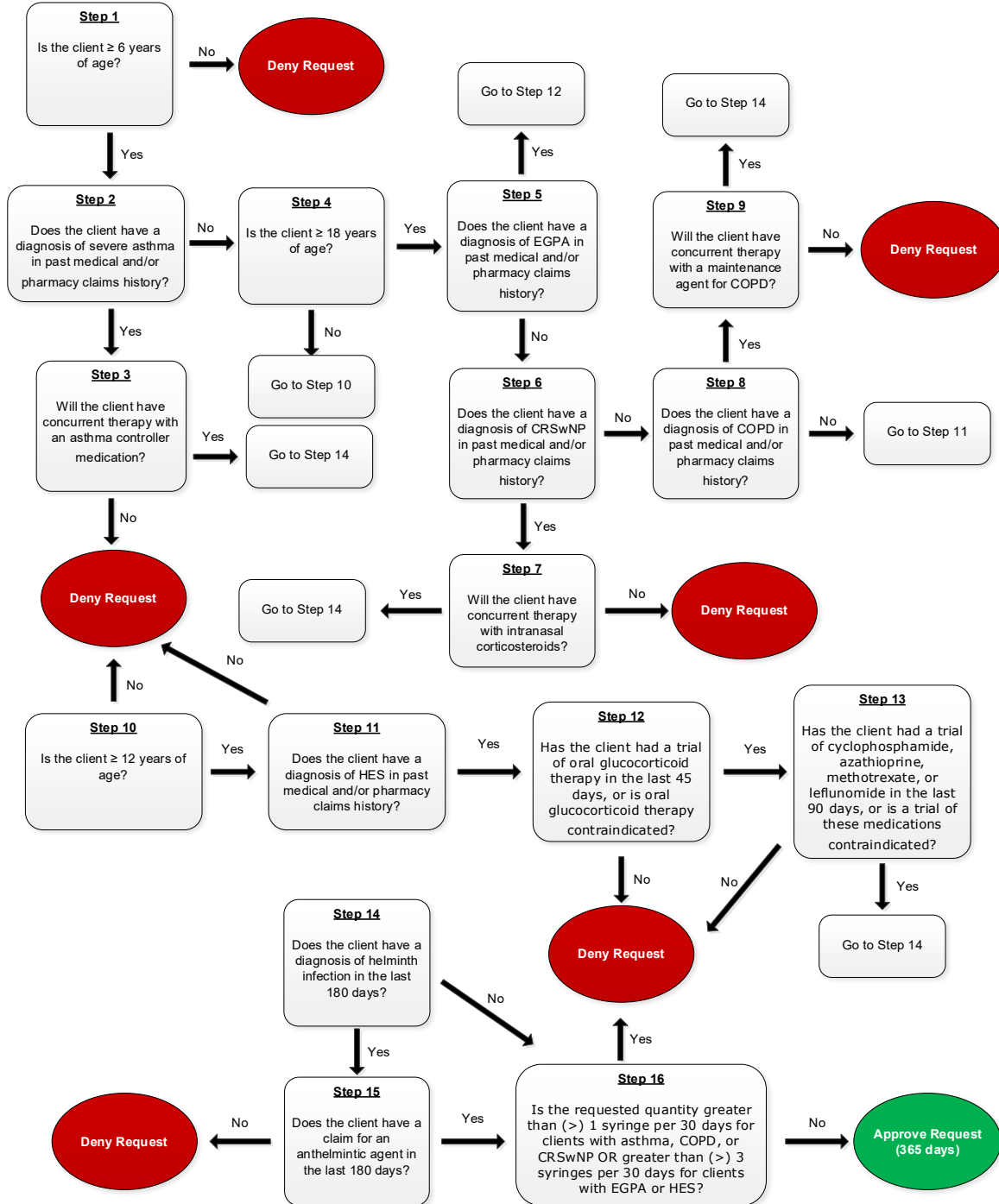
**Nucala (Mepolizumab)****Clinical Criteria Logic**

1. Is the client greater than or equal to (\geq) 6 years of age?
 Yes – Go to #2
 No – Deny
2. Does the client have a [diagnosis of severe asthma](#) in past medical and/or pharmacy claims history?
 Yes – Go to #3
 No – Go to #4
3. Will the client have concurrent therapy with an [asthma controller medication](#)?
 Yes – Go to #14
 No – Deny
4. Is the client greater than or equal to (\geq) 18 years of age?
 Yes – Go to #5
 No – Go to #10
5. Does the client have a [diagnosis of eosinophilic granulomatosis with polyangiitis \(EGPA\)](#) in past medical and/or pharmacy claims history?
 Yes – Go to #12
 No – Go to #6
6. Does the client have a [diagnosis of chronic rhinosinusitis with nasal polyps \(CRSwNP\)](#) in past medical and/or pharmacy claims history?
 Yes – Go to #7
 No – Go to #8
7. Will the client have concurrent therapy with [intranasal corticosteroids](#)?
 Yes – Go to #14
 No – Deny
8. Does the client have a [diagnosis of chronic obstructive pulmonary disease \(COPD\)](#) in past medical and/or pharmacy claims history?
 Yes – Go to #9
 No – Go to #11
9. Will the client have concurrent therapy with a [maintenance agent for COPD](#)?

- Yes – Go to #14
- No – Deny
10. Is the client greater than or equal to (\geq) 12 years of age?
- Yes – Go to #11
- No – Deny
11. Does the client have a [diagnosis of hypereosinophilic syndrome \(HES\)](#) in past medical and/or pharmacy claims history?
- Yes – Go to #12
- No – Deny
12. Has the client had a trial of [oral glucocorticoid therapy](#) in the last 45 days, or is oral glucocorticoid therapy contraindicated?
- Yes – Go to #13
- No – Deny
13. Has the client had a trial of [cyclophosphamide, azathioprine, methotrexate \(MTX\), or leflunomide](#) in the last 90 days, or is a trial of these medications contraindicated?
- Yes – Go to #14
- No – Deny
14. Does the client have a [diagnosis of helminth infection](#) in the last 180 days?
- Yes – Go to #15
- No – Go to #16
15. Does the client have a claim for an [anthelmintic agent](#) in the last 180 days?
- Yes – Go to #16
- No – Deny
16. Is the requested quantity greater than ($>$) 1 syringe per 30 days for clients with asthma, COPD, or CRSwNP OR greater than ($>$) 3 syringes per 30 days for clients with EGPA or HES?
- Yes – Deny
- No – Approve (365 days)



Nucala (Mepolizumab) Clinical Criteria Logic Diagram



**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

**Tezspire (Tezepelumab-ekko)****Clinical Criteria Logic**

Initial Requests:

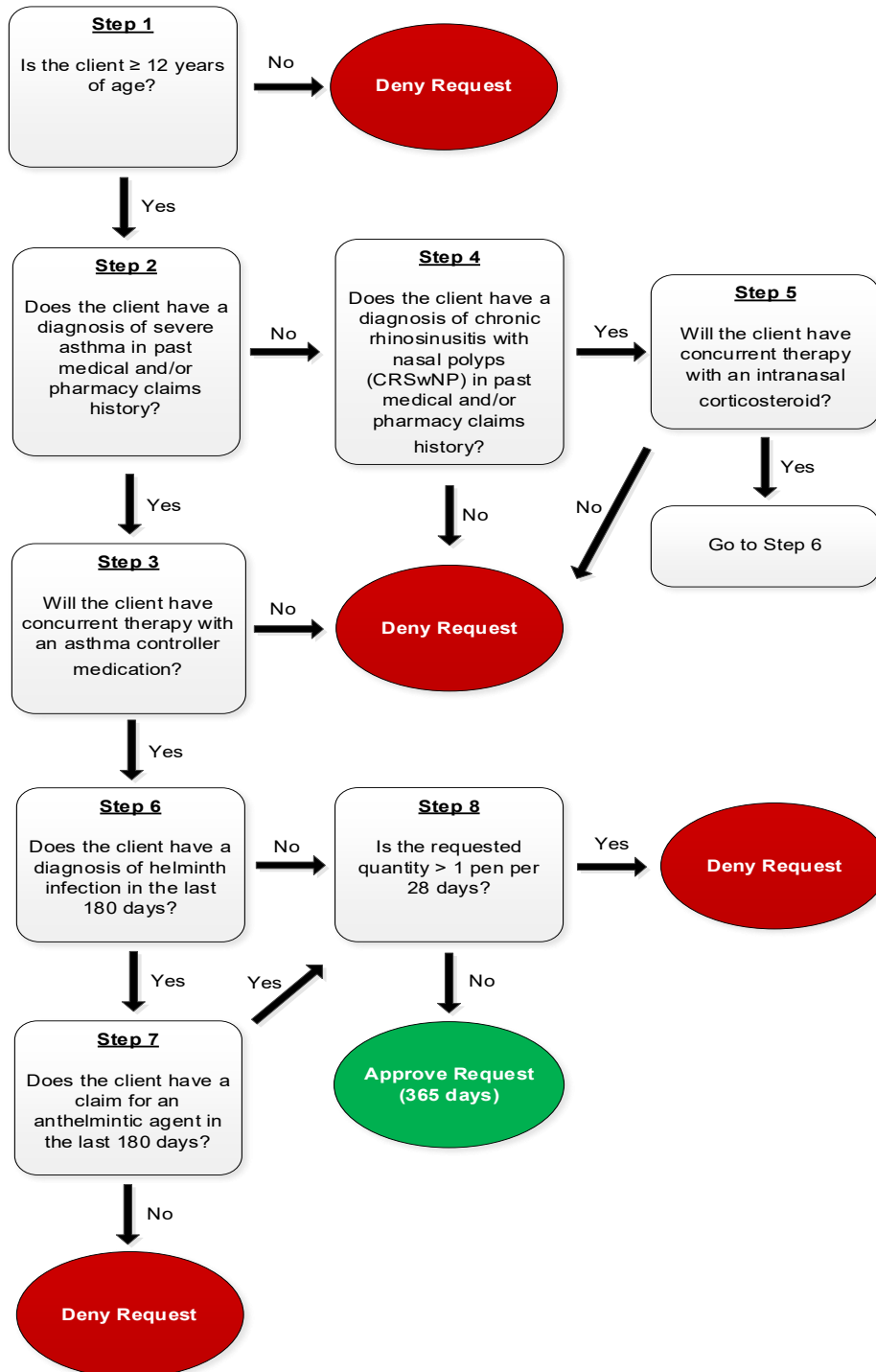
1. Is the client greater than or equal to (\geq) 12 years of age?
 - Yes – Go to #2
 - No – Deny
2. Does the client have a [diagnosis of severe asthma](#) in past medical and/or pharmacy claims history?
 - Yes – Go to #3
 - No – Go to #4
3. Will the client have concurrent therapy with an [asthma controller medication](#)?
 - Yes – Go to #6
 - No – Deny
4. Does the client have a [diagnosis of chronic rhinosinusitis with nasal polyps \(CRSwNP\)](#) in past medical and/or pharmacy claims history?
 - Yes – Go to #5
 - No – Deny
5. Will the client have concurrent therapy with an [intranasal corticosteroid](#)?
 - 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. Is the requested quantity greater than ($>$) 1 pen per 28 days?
 - Yes – Deny
 - No – Approve (365 days)

Renewal Requests:

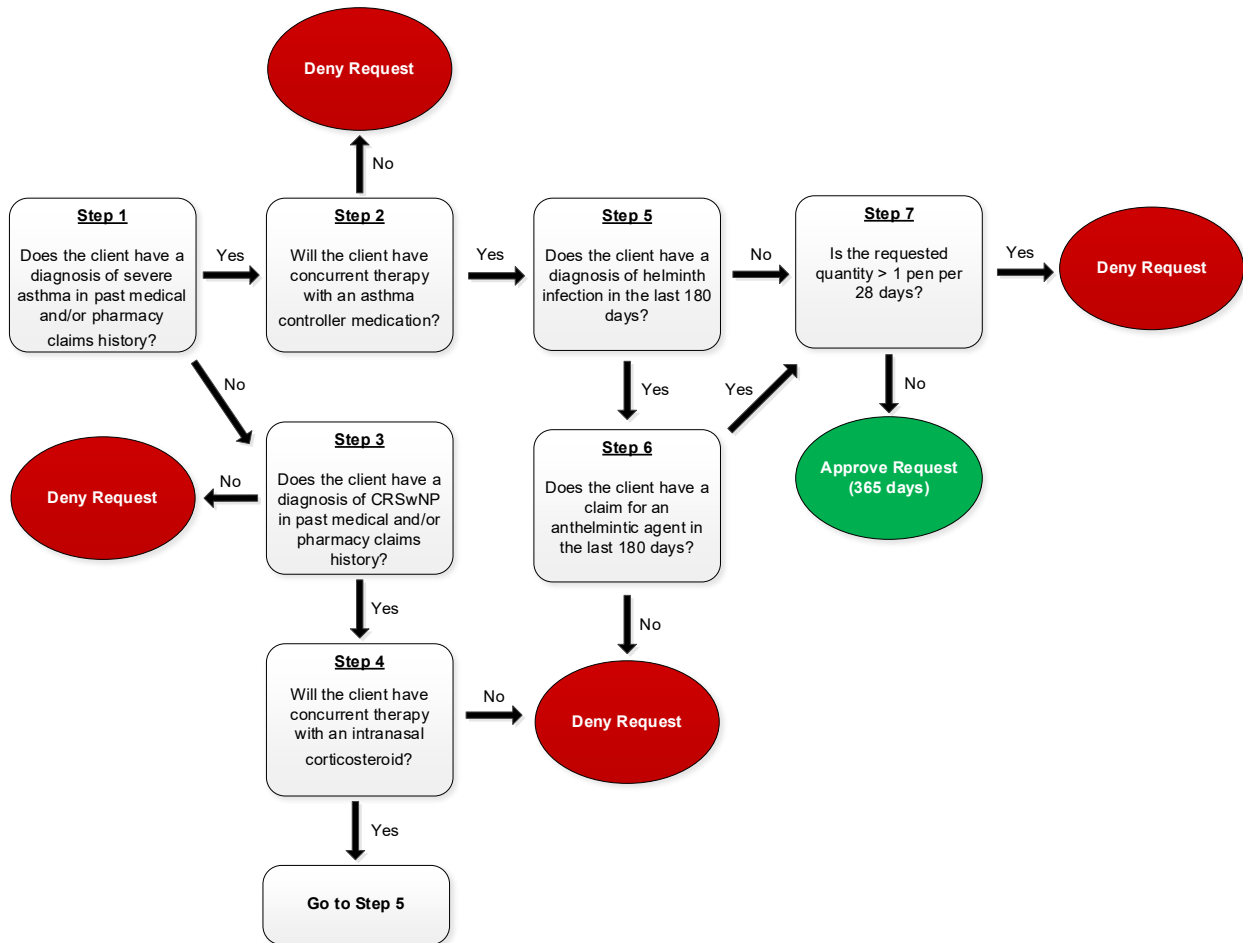
1. Does the client have a [diagnosis of severe asthma](#) in past medical and/or pharmacy claims history?
 Yes – Go to #2
 No – Go to #3
2. Will the client have concurrent therapy with an [asthma controller medication](#)?
 Yes – Go to #5
 No – Deny
3. Does the client have a [diagnosis of chronic rhinosinusitis with nasal polyps \(CRSwNP\)](#) in past medical and/or pharmacy claims history?
 Yes – Go to #4
 No – Deny
4. Will the client have concurrent therapy with an [intranasal corticosteroid](#)?
 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. Is the requested quantity greater than (>) 1 pen per 28 days?
 Yes – Deny
 No – Approve (365 days)

PAXPRESS™ **Tezspire (Tezepelumab-ekko)**
Clinical Criteria Logic Diagram

Initial Requests:



Renewal Requests:





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

**Xolair (Omalizumab)****Clinical Criteria Logic**

Initial Requests:

1. Is the client greater than or equal to (\geq) 1 year of age?
 Yes – Go to #2
 No – Deny
2. Does the client have a [diagnosis of IgE-mediated food allergy](#) in past medical and/or pharmacy claims history?
 Yes – Go to #20
 No – Go to #3
3. Is the client greater than or equal to (\geq) 6 years of age?
 Yes – Go to #4
 No – Deny
4. Does the client have a [diagnosis of moderate to severe persistent asthma](#) in past medical and/or pharmacy claims history?
 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)?
- Yes – Go to #9
- No – Go to #11
9. Does the client weigh more than 150 kg?
- 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?
- Yes – Go to #21
- No – Go to #11
11. Does the client have a [diagnosis of chronic spontaneous urticaria \(CSU\)](#) in past medical and/or pharmacy claims history?
- Yes – Go to #12
- No – Go to #15
12. Is the client greater than or equal to (\geq) 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?
- Yes – Go to #21
- No – Go to #15
15. Does the client have a [diagnosis of nasal polyps](#) in past medical and/or pharmacy claims history?
- Yes – Go to #16
- No – Deny
16. Is the client greater than or equal to (\geq) 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?
- Yes – Go to #19
- No – Deny
19. Does the client weigh more than 150 kg?
- 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?
- 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)

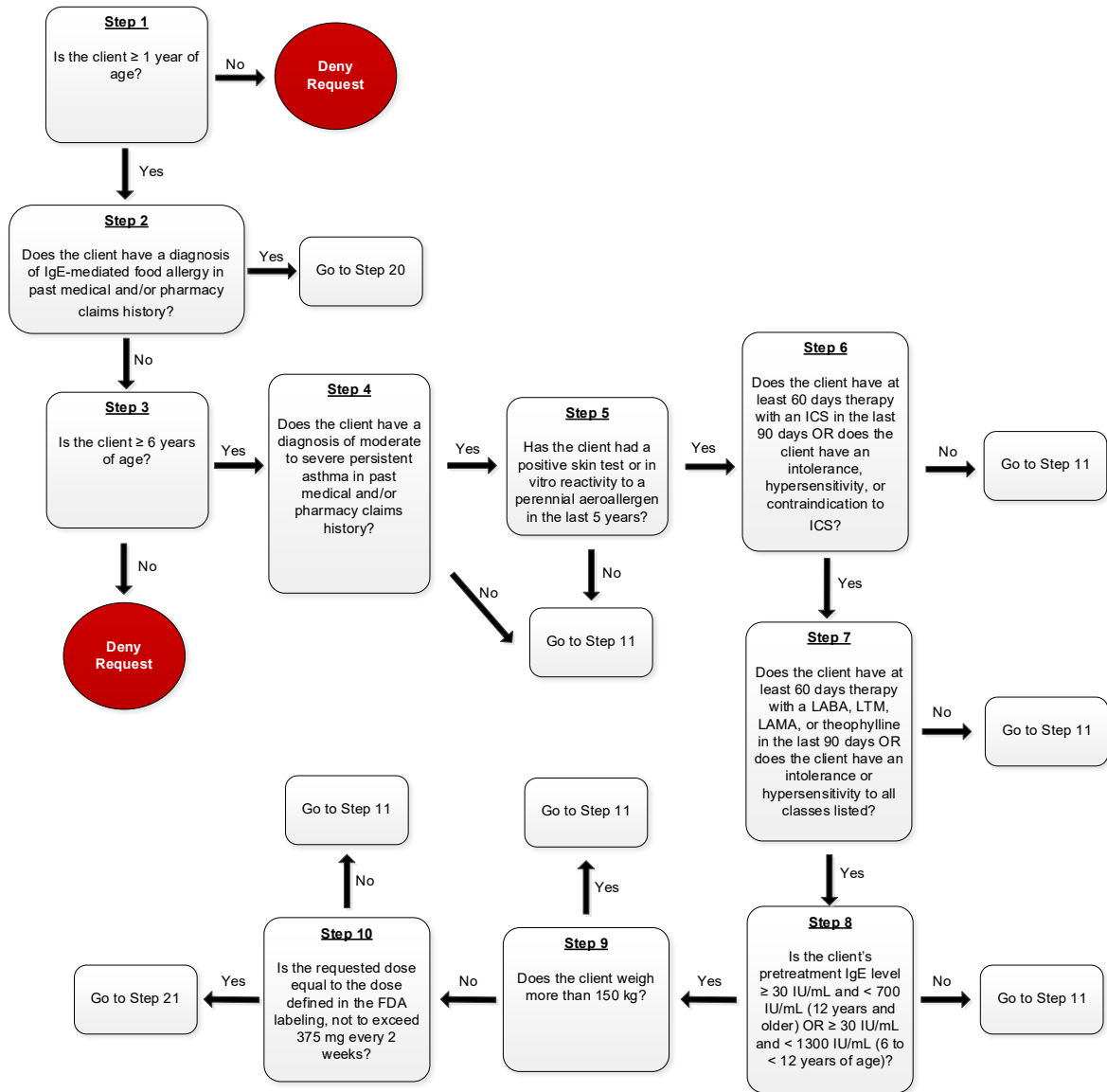
Renewal Requests:

1. Does the client have a [diagnosis of IgE-mediated food allergy](#) in past medical and/or pharmacy claims history?
 Yes – Go to #11
 No – Go to #2
2. Does the client have a [diagnosis of moderate to severe persistent asthma](#) in past medical and/or pharmacy claims history?
 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 150 kg?
 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?
 Yes – Go to #12
 No – Go to #6
6. Does the client have a [diagnosis of chronic spontaneous urticaria](#) in past medical and/or pharmacy claims history?
 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?
 Yes – Go to #12
 No – Go to #8
8. Does the client have a [diagnosis of nasal polyps](#) in past medical and/or pharmacy claims history?
 Yes – Go to #9
 No – Deny

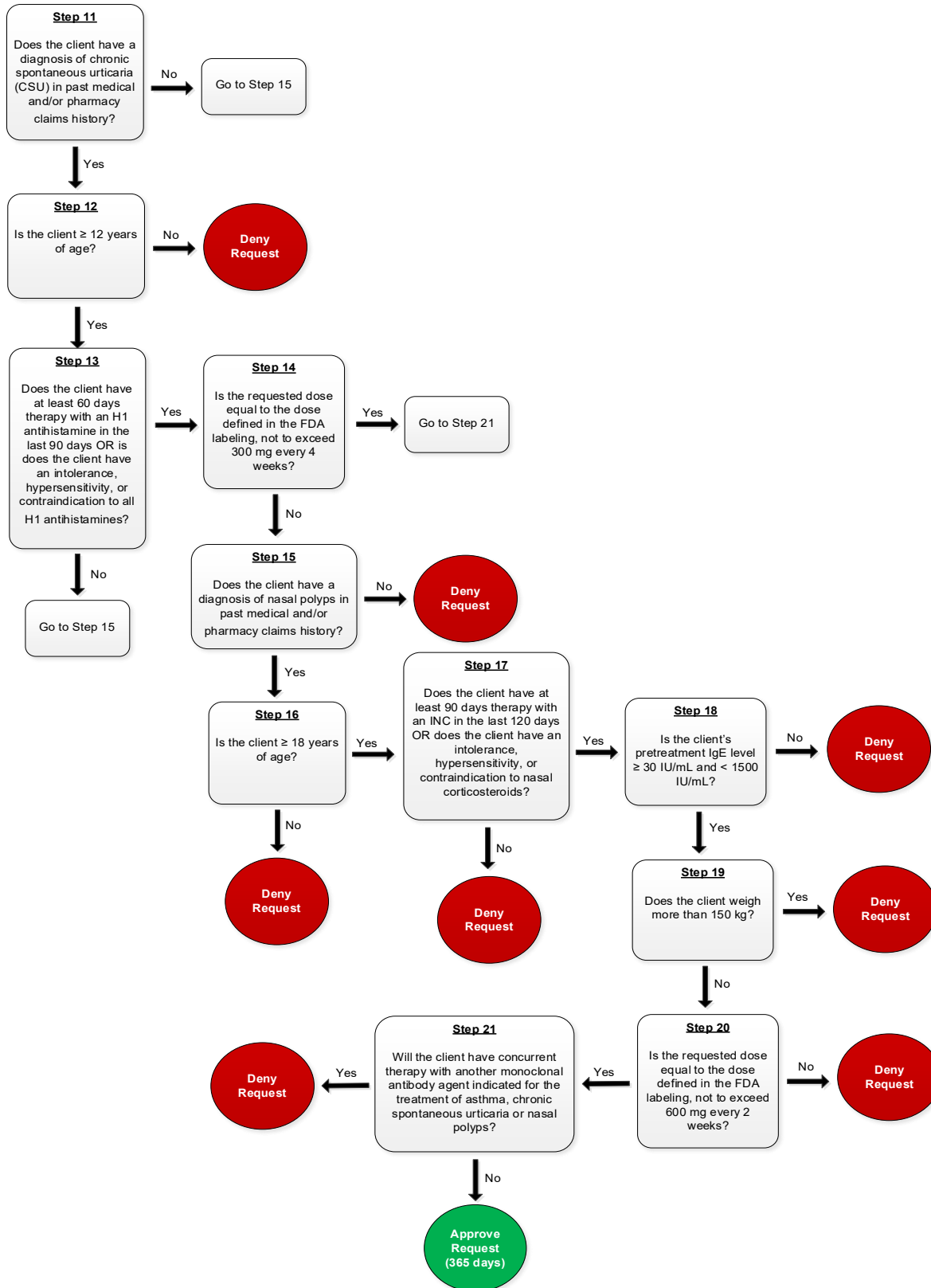
9. Does the client have current therapy with an [intranasal corticosteroid](#) that will continue during therapy with Xolair OR does the client have an intolerance, hypersensitivity, or contraindication to nasal corticosteroids?
- Yes – Go to #10
- No – Deny
10. Does the client weigh more than 150 kg?
- 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?
- 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)

PAXPRESS™ **Xolair (Omalizumab)**
Clinical Criteria Logic Diagram

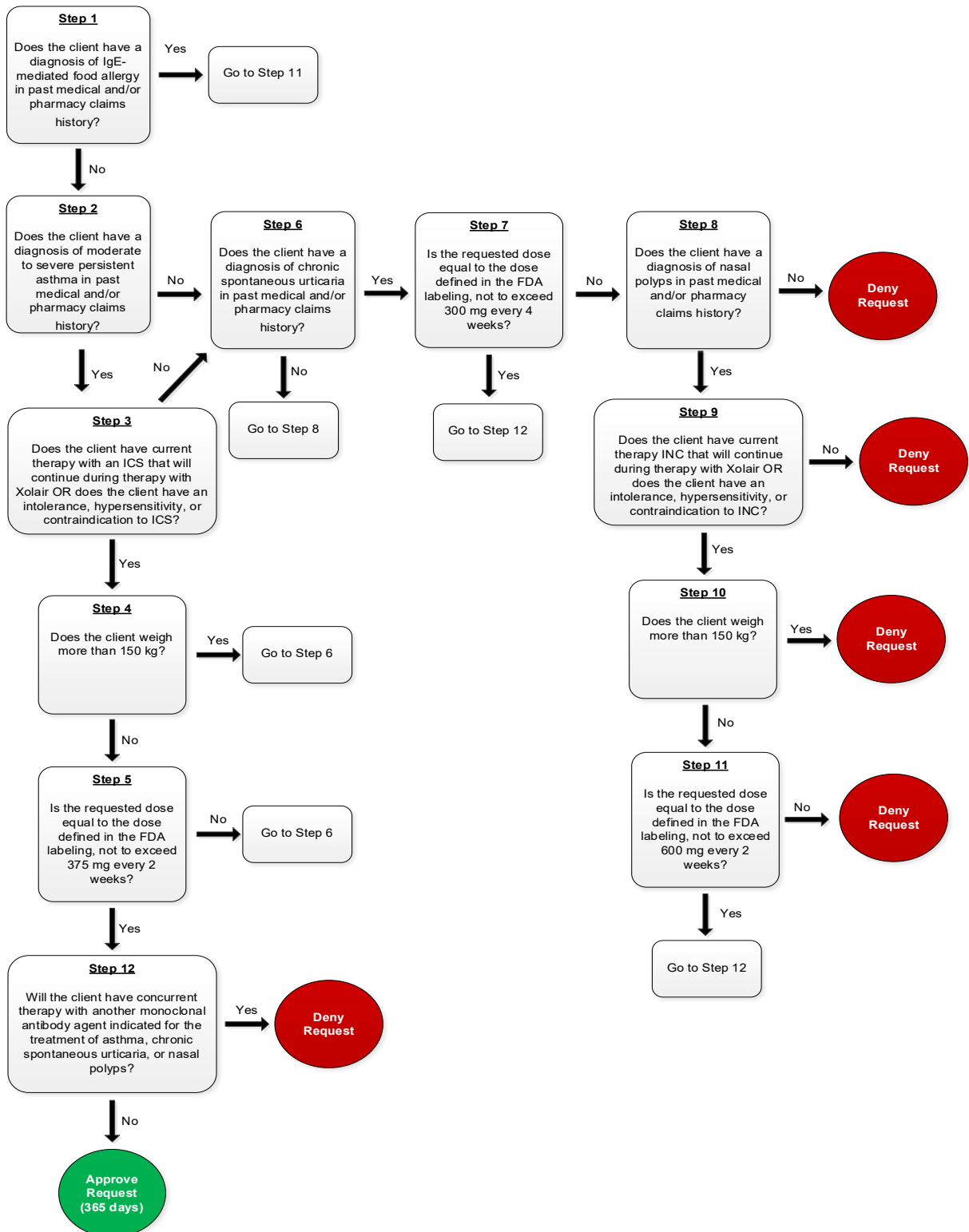
Initial Requests:



Initial Requests, Continued:



Renewal Requests:





Monoclonal Antibody Agents

Clinical Criteria Supporting Tables

Allergic Fungal Rhinosinusitis	
ICD-10 Code	Description
J3089	OTHER ALLERGIC RHINITIS

Allergen testing	
ICD-10 Code	Description
Z0182	ENCOUNTER FOR ALLERGY TESTING

Anthelmintic Agent	
GCN	Label Name
53290	ALBENDAZOLE 200 MG TABLET
53290	ALBENZA 200 MG TABLET
08490	BILTRICIDE 600 MG TABLET
43181	EMVERM 100 MG TABLET CHEW
93064	IVERMECTIN 3 MG TABLET
39561	IVERMECTIN 6 MG TABLET
08490	PRAZQUANTEL 600 MG TABLET
93064	STROMEKTOL 3 MG TABLET
39561	STROMEKTOL 6 MG TABLET

Asthma Controller Medication	
GCN	Label Name
50584	ADVAIR 100-50 DISKUS

Asthma Controller Medication	
GCN	Label Name
50594	ADVAIR 250-50 DISKUS
50604	ADVAIR 500-50 DISKUS
97136	ADVAIR HFA 115-21MCG INHALER
97137	ADVAIR HFA 230-21MCG INHALER
97135	ADVAIR HFA 45-21MCG INHALER
48494	AIRDUO DIGIHALER 113-14MCG
48495	AIRDUO DIGIHALER 232-14MCG
48489	AIRDUO DIGIHALER 55-14MCG
53534	AIRSUPRA 90-80MCG INHALER
24152	ALVESCO 160 MCG INHALER
24149	ALVESCO 80 MCG INHALER
42985	ARMONAIR RESPICLICK 232MCG
42979	ARMONAIR RESPICLICK 55MCG
48602	ARMONAIR DIGIHALER 55MCG
48604	ARMONAIR DIGIHALER 113 MCG
48615	ARMONAIR DIGIHALER 232 MCG
37007	ARNUITY ELLIPTA 100 MCG INH
37008	ARNUITY ELLIPTA 200 MCG INH
44783	ARNUITY ELLIPTA 50 MCG INH
37566	ASMANEX HFA 100 MCG INHALER
37565	ASMANEX HFA 200 MCG INHALER
99721	ASMANEX TWISTHALER 110 MCG #30
24928	ASMANEX TWISTHALER 220 MCG #30
24929	ASMANEX TWISTHALER 220 MCG #60

Asthma Controller Medication	
GCN	Label Name
18987	ASMANEX TWISTHALR 220 MCG #120
47599	ASMANEX HFA 50 MCG INHALER
37566	ASMANEX HFA 100 MCG INHALER
37565	ASMANEX HFA 200 MCG INHALER
34647	BREO ELLIPTA 100-25MCG INH
35808	BREO ELLIPTA 200-25MCG INHALER
98500	BREYNA 160-4.5MCG INHALER
98499	BREYNA 80-4.5MCG INHALER
48435	BREZTRI AEROSPHERE INHALER
17957	BUDESONIDE 0.25MG/2ML INHALATION SUSPENSION
17958	BUDESONIDE 0.5MG/2ML INHALATION SUSPENSION
62980	BUDESONIDE 1MG/2ML INHALATION SUSPENSION
98500	BUDESONIDE-FORMOTEROL 160-4.5MCG
98499	BUDESONIDE-FORMOTEROL 80-4.5MCG
28766	DULERA 100 MCG/5 MCG INHALER
28767	DULERA 200 MCG/5 MCG INHALER
53633	FLOVENT 100MCG DISKUS
53634	FLOVENT 250MCG DISKUS
53635	FLOVENT 50MCG DISKUS
53636	FLOVENT HFA 110 MCG INHALER
53639	FLOVENT HFA 220 MCG INHALER
53638	FLOVENT HFA 44 MCG INHALER
53633	FLUTICASONE PROP 100MCG DISKUS
53634	FLUTICASONE PROP 250MCG DISKUS

Asthma Controller Medication	
GCN	Label Name
53635	FLUTICASONE PROP 50MCG DISKUS
53636	FLUTICASONE PROP HFA 110MCG
53639	FLUTICASONE PROP HFA 220MCG
53638	FLUTICASONE PROP HFA 44MCG
42956	FLUTICASONE-SALMETEROL 55-14
42957	FLUTICASONE-SALMETEROL 113-14
42958	FLUTICASONE-SALMETEROL 232-14
34647	FLUTICASONE-VILANTEROL 100-25
35808	FLUTICASONE-VILANTEROL 200-25
26782	HYDROCORTISONE 20MG TABLET
26783	HYDROCORTISONE 5MG TABLET
26781	HYDROCORTONE 10MG TABLET
27051	MEDROL 16MG TABLET
27055	MEDROL 32MG TABLET
27056	MEDROL 4MG TABLET
27058	MEDROL 8MG TABLET
27051	METHYLPREDNISOLONE 16MG TABLET
27055	METHYLPREDNISOLONE 32MG TABLET
27056	METHYLPREDNISOLONE 4MG TABLET
27058	METHYLPREDNISOLONE 8MG TABLET
26963	MILLIPRED 5MG TABLET
99610	PREDNISOLONE 10MG/5ML SOLN
26800	PREDNISOLONE 15MG/5ML SOLN
33806	PREDNISOLONE 15MG/5ML SOLN

Asthma Controller Medication	
GCN	Label Name
14565	PREDNISOLONE 20MG/5ML SOLN
09115	PREDNISOLONE 5MG/5ML SOLUTION
27108	PREDNISOLONE ODT 10MG TABLET
27109	PREDNISOLONE ODT 15MG TABLET
27114	PREDNISOLONE ODT 30MG TABLET
27172	PREDNISONE 10MG TABLET
27171	PREDNISONE 1MG TABLET
27173	PREDNISONE 2.5MG TABLET
27174	PREDNISONE 20MG TABLET
27176	PREDNISONE 5 MG TABLET
27177	PREDNISONE 50MG TABLET
27160	PREDNISONE 5MG/5ML SOLUTION
27161	PREDNISONE 5MG/5ML SOLUTION
17957	PULMICORT 0.25 MG/2 ML RESPULE
17958	PULMICORT 0.5MG/2ML RESPULE
62980	PULMICORT 1 MG/2 ML RESPULE
98025	PULMICORT 180 MCG FLEXHALER
98024	PULMICORT 90 MCG FLEXHALER
43724	QVAR REDIHALER 40 MCG
43725	QVAR REDIHALER 80 MCG
98500	SYMBICORT 160-4.5 MCG INHALER
98499	SYMBICORT 80-4.5 MCG INHALER
43921	TRELEGY ELLIPTA 100-62.5-25
48708	TRELEGY ELLIPTA 200-62.5-25

Asthma Controller Medication	
GCN	Label Name
50584	WIXELA 100-50 INHUB
50594	WIXELA 250-50 INHUB
50604	WIXELA 500-50 INHUB

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
J8283	EOSINOPHILIC ASTHMA
J8289	OTHER 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
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

Bullous Pemphigoid	
ICD-10 Code	Description
L120	BULLOUS PEMPHIGOID
L138	OTHER SPECIFIED BULLOUS DISORDERS
L139	BULLOUS DISORDER, UNSPECIFIED
L14	BULLOUS DISORDERS IN DISEASES CLASSIFIED ELSEWHERE

Chronic Spontaneous Urticaria	
ICD-10 Code	Description
L500	ALLERGIC URTICARIA

Chronic Spontaneous Urticaria	
ICD-10 Code	Description
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

COPD Controller Medication	
GCN	Label Name
50584	ADVAIR 100-50 DISKUS
50594	ADVAIR 250-50 DISKUS
50604	ADVAIR 500-50 DISKUS
97136	ADVAIR HFA 115-21 MCG INHALER
97137	ADVAIR HFA 230-21 MCG INHALER
97135	ADVAIR HFA 45-21 MCG INHALER
48494	AIRDUO DIGIHALER 113-14 MCG
48495	AIRDUO DIGIHALER 232-14 MCG
48489	AIRDUO DIGIHALER 55-14 MCG
35903	ANORO ELLIPTA 62.5-25 MCG INH

COPD Controller Medication	
GCN	Label Name
97366	ARFORMOTEROL 15 MCG/2 ML SOLN
24621	ATROVENT 17 MCG HFA INHALER
42230	ATROVENT INHALER
41199	BEVESPI AEROSPHERE INHALER
34647	BREO ELLIPTA 100-25 MCG INHALR
35808	BREO ELLIPTA 200-25 MCG INHALR
54747	BREO ELLIPTA 50-25 MCG INHALER
98500	BREYNA 160-4.5 MCG INHALER
98499	BREYNA 80-4.5 MCG INHALER
48435	BREZTRI AEROSPHERE INHALER
97366	BROVANA 15 MCG/2 ML SOLUTION
32395	COMBIVENT RESPIMAT 20-100 MCG
37735	DUAKLIR PRESSAIR 400-12MCG INH
98776	FORMOTEROL 20 MCG/2 ML NEB VL
36574	INCRUSE ELLIPTA 62.5 MCG INH
98776	PERFOROMIST 20 MCG/2 ML SOLN
64012	SEREVENT DISKUS 50 MCG
17853	SPIRIVA HANDIHALER 18 MCG CAP
98921	SPIRIVA RESPIMAT 2.5 MCG INH
38687	STIOLTO RESPIMAT INHAL SPRAY
36174	STRIVERDI RESPIMAT INHAL SPRAY
98500	SYMBICORT 160-4.5 MCG INHALER
98499	SYMBICORT 80-4.5 MCG INHALER
43921	TRELEGY ELLIPTA 100-62.5-25

COPD Controller Medication	
GCN	Label Name
48708	TRELEGY ELLIPTA 200-62.5-25
33084	TUDORZA PRESSAIR 400 MCG INHAL
50584	WIXELA 100-50 INHUB
50594	WIXELA 250-50 INHUB
50604	WIXELA 500-50 INHUB
45742	YUPELRI 175 MCG/3 ML SOLUTION

Crisaborole, Pimecrolimus, or Topical Tacrolimus	
GCN	Label Name
15348	ELIDEL 1% CREAM
42792	EUCRISA 2% OINTMENT
15348	PIMECROLIMUS 1% CREAM
12289	PROTOPIC 0.03% OINTMENT
12302	PROTOPIC 0.1% OINTMENT
12289	TACROLIMUS 0.03% OINTMENT
12302	TACROLIMUS 0.1% OINTMENT

Cyclophosphamide, Azathioprine, Methotrexate, or Leflunomide	
GCN	Label Name
67031	ARAVA 10MG TABLET
67032	ARAVA 20MG TABLET
67033	ARAVA 100 MG TABLET
46771	AZATHIOPRINE 50MG TABLET
19170	AZATHIOPRINE 75 MG TABLET

Cyclophosphamide, Azathioprine, Methotrexate, or Leflunomide	
GCN	Label Name
19173	AZATHIOPRINE 100 MG TABLET
35317	CYCLOPHOSPHAMIDE 25MG CAPSULE
35318	CYCLOPHOSPHAMIDE 50MG CAPSULE
38360	CYCLOPHOSPHAMIDE 25 MG TAB
38361	CYCLOPHOSPHAMIDE 50 MG TABLET
67031	LEFLUNOMIDE 10MG TABLET
67032	LEFLUNOMIDE 20MG TABLET
38489	METHOTREXATE 2.5MG TABLET
18936	METHOTREXATE 50MG/2ML VIAL
39393	OTREXUP 7.5 MG/0.4 ML AUTO-INJ
35427	OTREXUP 10MG/0.4ML AUTO-INJ
41774	OTREXUP 12.5 MG/0.4 ML AUTOINJ
35428	OTREXUP 15MG/0.4ML AUTO-INJ
41007	OTREXUP 17.5 MG/0.4 ML AUTOINJ
35437	OTREXUP 20MG/0.4ML AUTO-INJ
41008	OTREXUP 22.5 MG/0.4 ML AUTOINJ
35438	OTREXUP 25MG/0.4ML AUTO-INJ
36847	RASUVO 10MG/0.2ML AUTOINJ
36848	RASUVO 12.5MG/0.25ML AUTOINJ
36849	RASUVO 15MG/0.3ML AUTOINJ
36851	RASUVO 17.5MG/0.35ML AUTOINJ
35437	RASUVO 20MG/0.4ML AUTOINJ
36852	RASUVO 22.5MG/0.45ML AUTOINJ
36853	RASUVO 25MG/0.5ML AUTOINJ

Cyclophosphamide, Azathioprine, Methotrexate, or Leflunomide	
GCN	Label Name
36854	RASUVO 27.5 MG/0.55 ML AUTOINJ
36855	RASUVO 30MG/0.6ML AUTOINJ
36846	RASUVO 7.5MG/0.15ML AUTOINJ
06484	TREXALL 10MG TABLET
13135	TREXALL 15MG TABLET
13134	TREXALL 5MG TABLET
38485	TREXALL 7.5MG TABLET
43319	XATMEP 2.5MG/ML ORAL SOLUTION

Duplicate Monoclonal Antibody Therapy	
GCN	Label Name
51749	ADBRY 150 MG/ML SYRINGE
55922	ADBRY 300 MG/2 ML AUTOINJECTOR ADBRY
40873	CINQAIR 100 MG/10 ML VIAL
51385	DUPIXENT 100 MG/0.67 ML SYRINGE
48785	DUPIXENT 200 MG/1.14 ML PEN
45522	DUPIXENT 200 MG/1.14 ML SYRINGE
48277	DUPIXENT 300 MG/2 ML PEN
43222	DUPIXENT 300 MG/2 ML SYRINGE
47019	FASENRA PEN 30 MG/ML
44088	FASENRA 30 MG/ML SYRINGE
55559	FASENRA 10 MG/0.5 ML SYRINGE
46414	NUCALA 100 MG/ML AUTO-INJECTOR
46413	NUCALA 100 MG/ML SYRINGE

Duplicate Monoclonal Antibody Therapy	
GCN	Label Name
52416	NUCALA 40 MG/0.4 ML SYRINGE
40084	NUCALA 100 MG/ML POWDER VIAL
53116	TEZSPIRE 210 MG/1.91 ML PEN
51748	TEZSPIRE 210 MG/1.91 ML SYRING

Eosinophilic Asthma	
ICD-10 Code	Description
J8283	EOSINOPHILIC ASTHMA
J8289	OTHER PULMONARY EOSINOPHILIA, NOT ELSEWHERE CLASSIFIED

Eosinophilic Esophagitis	
ICD-10 Code	Description
K200	EOSINOPHILIC ESOPHAGITIS

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

Oral Glucocorticoids	
GCN	Label Name
26782	HYDROCORTISONE 20MG TABLET
26783	HYDROCORTISONE 5MG TABLET
26781	HYDROCORTONE 10MG TABLET
27051	MEDROL 16MG TABLET

Oral Glucocorticoids	
GCN	Label Name
27055	MEDROL 32MG TABLET
27056	MEDROL 4MG TABLET
27058	MEDROL 8MG TABLET
27051	METHYLPREDNISOLONE 16MG TABLET
27055	METHYLPREDNISOLONE 32MG TABLET
27056	METHYLPREDNISOLONE 4MG TABLET
27058	METHYLPREDNISOLONE 8MG TABLET
26963	MILLIPRED 5MG TABLET
99610	PREDNISOLONE 10MG/5ML SOLN
26800	PREDNISOLONE 15MG/5ML SOLN
33806	PREDNISOLONE 15MG/5ML SOLN
14565	PREDNISOLONE 20MG/5ML SOLN
09115	PREDNISOLONE 5MG/5ML SOLUTION
27108	PREDNISOLONE ODT 10MG TABLET
27109	PREDNISOLONE ODT 15MG TABLET
27114	PREDNISOLONE ODT 30MG TABLET
27172	PREDNISONE 10MG TABLET
27171	PREDNISONE 1MG TABLET
27173	PREDNISONE 2.5MG TABLET
27174	PREDNISONE 20MG TABLET
27176	PREDNISONE 5 MG TABLET
27177	PREDNISONE 50MG TABLET
27160	PREDNISONE 5MG/5ML SOLUTION
27161	PREDNISONE 5MG/5ML SOLUTION

H1 Antihistamine	
GCN	Label Name
14901	24HR ALLERGY (LEVOCETIRZN) 5 MG
49291	ALL DAY ALLERGY 10 MG TABLET
46512	ALLER-CHLOR 4MG TABLET
60563	ALLERGY (LORATADINE) 10 MG TAB
45971	ALLERGY 25 MG CAPSULE
46512	ALLERGY 4 MG TABLET
60563	ALLERGY RELIEF 10 MG TAB
46594	ALLERGY RELIEF 180 MG TABLET
45971	ALLERGY RELIEF 25 MG SOFTGEL
46071	ALLERGY RELIEF 25 MG TABLET
46512	ALLERGY RELIEF 4 MG TABLET
60562	ALLERGY RELIEF 5 MG/5 ML SOLN
63570	ALLERGY RELIEF D-12 TABLET
63577	ALLERGY RELIEF D-24HR TABLET
13866	ALLERGY RELIEF-D TABLET
49291	ALLERGY RLF (CETRZN) 10 MG TAB
63565	ALLERGY-CONGEST 12HR 60-120 MG
45971	BANOPHEN 25 MG CAPSULE
45972	BANOPHEN 50 MG CAPSULE
49290	CETIRIZINE HCL 1 MG/ML SOLN
49290	CETIRIZINE HCL 1 MG/ML SYRUP
49290	CETIRIZINE HCL 1 MG/ML SYRUP
21771	CETIRIZINE HCL 10 MG CHEW TAB
49291	CETIRIZINE HCL 10 MG TABLET

H1 Antihistamine	
GCN	Label Name
21769	CETIRIZINE HCL 5 MG CHEW TAB
49292	CETIRIZINE HCL 5 MG TABLET
27714	CETIRIZINE HCL 5 MG/5 ML SYRUP
13866	CETIRIZINE-PSE ER 5-120 MG TAB
49290	CHILD ALL DAY ALLERGY 1 MG/ML
49290	CHILD ALLERGY RELIEF 1 MG/ML
60562	CHILD ALLERGY RELIEF 5MG/5 ML
48831	CHILD ALLERGY RLF 12.5 MG/5 ML
21771	CHILD CETIRIZINE 10 MG CHEW TAB
21769	CHILD CETIRIZINE 5 MG CHEW TAB
49290	CHILD CETIRIZINE HCL 1 MG/ML SOL
45393	CHILD LORATADINE 10 MG/10 ML
60562	CHILD LORATADINE 5 MG/5 ML SOL
46461	CHLORPHENIRAMINE 12 MG CP SA
46541	CHLORPHENIRAMINE 12 MG TB SA
46503	CHLORPHENIRAMINE 2 MG/5 ML SY
46512	CHLORPHENIRAMINE 4 MG TABLET
46464	CHLORPHENIRAMINE 8 MG CAP SA
46544	CHLORPHENIRAMINE 8 MG TAB SA
96098	CHLORPHENIRAMINE/APAP TAB
12762	CLARINEX 5 MG TABLET
26558	CLARINEX-D 12 HR 2.5-120 MG TAB
46990	CLEMASTINE 0.5 MG/5 ML SYRUP
46990	CLEMASTINE 0.67 MG/5 ML SYRUP

H1 Antihistamine	
GCN	Label Name
46690	CLEMASTINE FUM 1.34 MG TAB
46691	CLEMASTINE FUM 2.68 MG TAB
15803	CYPROHEPTADINE 2 MG/5 ML SYRUP
15811	CYPROHEPTADINE 4 MG TABLET
25439	DES Loratadine 2.5 MG ODT
19716	DES Loratadine 5 MG ODT
12762	DES Loratadine 5 MG TABLET
28379	DEXBROMPHENIR-PHENYLEPH 2-10 MG
46550	DEXCHLORPHEN 2 MG/5 ML SYRUP
46570	DEXCHLORPHENIRAMINE 4 MG TAB
46571	DEXCHLORPHENIRAMINE 6 MG TAB
18231	DIMENHYDRINATE 50 MG TABLET
18190	DIMENHYDRINATE 50 MG/ML SYRN
45971	DIPHENHIST 25 MG CAPSULE
48831	DIPHENHYDRAMINE 12.5 MG/5 ML
46032	DIPHENHYDRAMINE 12.5MG/5ML CUP
48831	DIPHENHYDRAMINE 12.5MG/5ML CUP
45971	DIPHENHYDRAMINE 25 MG CAPSULE
27481	DIPHENHYDRAMINE 25 MG TABLET
46071	DIPHENHYDRAMINE 25 MG TABLET
45972	DIPHENHYDRAMINE 50 MG CAPSULE
46000	DIPHENHYDRAMINE 50 MG/ML SYN
46001	DIPHENHYDRAMINE 50 MG/ML SYN
42545	DIPHENHYDRAMINE 6.25 MG/ML

H1 Antihistamine	
GCN	Label Name
46062	DIPHENHYDRAMINE COUGH SYRUP
46032	DIPHENHYDRAMINE ELIXIR
46062	DIPHENHYDRAMINE SYRUP
46594	FEXOFENADINE HCL 180 MG TABLET
37198	FEXOFENADINE HCL 30 MG TABLET
97779	FEXOFENADINE HCL 30 MG/5 ML
46593	FEXOFENADINE HCL 60 MG TABLET
63565	FEXOFENADINE PSE ER 60-120 TAB
60563	GNP LORATADINE 10 MG TABLET
60563	GS ALLERGY RELIEF 10 MG TABLET
13932	HYDROXYZINE 10 MG/5 ML SYRUP
13901	HYDROXYZINE 25 MG/ML SYRINGE
13901	HYDROXYZINE 25 MG/ML TUBEX
13881	HYDROXYZINE 25 MG/ML VIAL
13900	HYDROXYZINE 50 MG/ML SYRINGE
13900	HYDROXYZINE 50 MG/ML TUBEX
13882	HYDROXYZINE 50 MG/ML VIAL
13941	HYDROXYZINE HCL 10 MG TABLET
13943	HYDROXYZINE HCL 25 MG TABLET
13944	HYDROXYZINE HCL 50 MG TABLET
13951	HYDROXYZINE PAM 100 MG CAP
13952	HYDROXYZINE PAM 25 MG CAP
13953	HYDROXYZINE PAM 50 MG CAP
97950	LEVOCETIRIZINE 2.5 MG/5 ML SOL

H1 Antihistamine	
GCN	Label Name
14901	LEVOCETIRIZINE 5 MG TABLET
60521	LORATADINE 10 MG ODT
60563	LORATADINE 10 MG TABLET
60562	LORATADINE 5 MG/5 ML SYRUP
60562	LORATADINE ALLERGY 5 MG/5 ML
63570	LORATADINE-D 12 HOUR TABLET
63577	LORATADINE-D 24HR TABLET
18301	MECLIZINE 12.5 MG TABLET
18302	MECLIZINE 25 MG TABLET
18312	MECLIZINE 25 MG TABLET CHEW
15042	PROMETHAZINE 12.5 MG TABLET
15043	PROMETHAZINE 25 MG TABLET
15044	PROMETHAZINE 50 MG TABLET
15035	PROMETHAZINE 6.25 MG/5 ML SYR
52370	PROMETHAZINE VC SYRUP
52380	PROMETHAZINE VC/COD SYRUP
52360	PROMETHAZINE/CODEINE SYRUP
48831	QC CHILD ALLERGY 12.5 MG/5 ML
45971	QC COMPLETE ALLERGY 25 MG CAP
60521	RA LORATADINE 10 MG ODT
60563	RA LORATADINE 10 MG TABLET
60562	RA LORATADINE 5 MG/5 ML SYRUP
48831	SILADRYL 12.5 MG/5 ML
45972	SK-DIPHENHYDRAMINE 50 MG CAP

H1 Antihistamine	
GCN	Label Name
48831	SM ALLERGY RELIEF 12.5 MG/5 ML
60562	SM CHILD LORATADINE 5 MG/5 ML
60521	SM LORATADINE 10 MG ODT
60563	SM LORATADINE 10 MG TABLET
60562	SM LORATADINE 5 MG/5 ML SYRUUP
63577	SM LORATADINE D 24HR TABLET
63570	SM LORATADINE-D 12 HOUR TABLET
13952	VISTARIL 25 MG CAPSULE
13953	VISTARIL 50 MG CAPSULE

Helminth Infection	
ICD-10 Code	Description
B650	SCHISTOSOMIASIS DUE TO SCHISTOSOMA HAEMATOBIIUM [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

Helminth Infection	
ICD-10 Code	Description
B665	FASCIOLOPSIASIS
B668	OTHER SPECIFIED FLUKE INFECTIONS
B669	FLUKE INFECTION, UNSPECIFIED
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

Helminth Infection	
ICD-10 Code	Description
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
B743	LOIASIS
B744	MANSONELLIASIS
B748	OTHER FILARIASES
B749	FILARIASIS, UNSPECIFIED
B75	TRICHINELLOSIS
B760	ANCYLOSTOMIASIS
B761	NECATORIASIS
B768	OTHER HOOKWORM DISEASES

Helminth Infection	
ICD-10 Code	Description
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

Helminth Infection	
ICD-10 Code	Description
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)	
GCN	Label Name
50584	ADVAIR 100-50 DISKUS
50594	ADVAIR 250-50 DISKUS
50604	ADVAIR 500-50 DISKUS

Inhaled Corticosteroid (ICS)	
GCN	Label Name
97136	ADVAIR HFA 115-21MCG INHALER
97137	ADVAIR HFA 230-21MCG INHALER
97135	ADVAIR HFA 45-21MCG INHALER
42956	AIRDUO RESPICLICK 55-14 MCG
42957	AIRDUO RESPICLICK 113-14 MCG
42958	AIRDUO RESPICLICK 232-14 MCG
53534	AIRSUPRA 90-80MCG INHALER
24152	ALVESCO 160 MCG INHALER
24149	ALVESCO 80 MCG INHALER
42985	ARMONAIR RESPICLICK 232MCG
42979	ARMONAIR RESPICLICK 55MCG
48602	ARMONAIR DIGIHALER 55MCG
48604	ARMONAIR DIGIHALER 113 MCG
48615	ARMONAIR DIGIHALER 232 MCG
37007	ARNUITY ELLIPTA 100 MCG INH
37008	ARNUITY ELLIPTA 200 MCG INH
44783	ARNUITY ELLIPTA 50 MCG INH
37566	ASMANEX HFA 100 MCG INHALER
37565	ASMANEX HFA 200 MCG INHALER
47599	ASMANEX HFA 50 MCG INHALER
24927	ASMANEX TWISTHALER 220 MCG #14
99721	ASMANEX TWISTHALER 110 MCG #30
24928	ASMANEX TWISTHALER 220 MCG #30
24929	ASMANEX TWISTHALER 220 MCG #60

Inhaled Corticosteroid (ICS)	
GCN	Label Name
18987	ASMANEX TWISTHALR 220 MCG #120
34647	BREO ELLIPTA 100-25MCG INH
35808	BREO ELLIPTA 200-25MCG INHALER
98500	BREYNA 160-4.5MCG INHALER
98499	BREYNA 80-4.5MCG INHALER
48435	BREZTRI AEROSPHERE INHALER
17957	BUDESONIDE 0.25MG/2ML INHALATION SUSPENSION
17958	BUDESONIDE 0.5MG/2ML INHALATION SUSPENSION
62980	BUDESONIDE 1MG/2ML INHALATION SUSPENSION
98499	BUDESONIDE-FORMOTEROL 80-4.5
98500	BUDESONIDE-FORMOTEROL 160-4.5
28766	DULERA 100 MCG/5 MCG INHALER
28767	DULERA 200 MCG/5 MCG INHALER
30139	DULERA 50 MCG/5 MCG INHALER
53633	FLOVENT 100MCG DISKUS
53634	FLOVENT 250MCG DISKUS
53635	FLOVENT 50MCG DISKUS
53636	FLOVENT HFA 110 MCG INHALER
53639	FLOVENT HFA 220 MCG INHALER
53638	FLOVENT HFA 44 MCG INHALER
53633	FLUTICASONE PROP 100MCG DISKUS
53634	FLUTICASONE PROP 250MCG DISKUS
53635	FLUTICASONE PROP 50MCG DISKUS
53636	FLUTICASONE PROP HFA 110MCG

Inhaled Corticosteroid (ICS)	
GCN	Label Name
53639	FLUTICASONE PROP HFA 220MCG
53638	FLUTICASONE PROP HFA 44MCG
42956	FLUTICASONE-SALMETEROL 55-14
42957	FLUTICASONE-SALMETEROL 113-14
42958	FLUTICASONE-SALMETEROL 232-14
34647	FLUTICASONE-VILANTEROL 100-25
35808	FLUTICASONE-VILANTEROL 200-25
17957	PULMICORT 0.25 MG/2 ML RESPULE
17958	PULMICORT 0.5MG/2ML RESPULE
62980	PULMICORT 1 MG/2 ML RESPULE
98025	PULMICORT 180 MCG FLEXHALER
98024	PULMICORT 90 MCG FLEXHALER
43724	QVAR REDHALER 40 MCG
43725	QVAR REDHALER 80 MCG
98500	SYMBICORT 160-4.5 MCG INHALER
98499	SYMBICORT 80-4.5 MCG INHALER
43921	TRELEGY ELLIPTA 100-62.5-25
48708	TRELEGY ELLIPTA 200-62.5-25
50584	WIXELA 100-50 INHUB
50594	WIXELA 250-50 INHUB
50604	WIXELA 500-50 INHUB

Intranasal Corticosteroid (INC)	
GCN	Label Name
32099	AZELASTIN-FLUTIC 137-50 MCG SPR
47100	BECONASE AQ 0.042% SPRAY
92231	BUDESONIDE 32MCG NASAL SPRAY
37683	CHILD FLONASE ALLER RLF 50 MCG
42959	CHILD FLONASE SENSIMIST 27.5MCG
36145	CHILD NASACORT ALLERGY 24 HR
32099	DYMISTA NASAL SPRAY
37683	FLONASE ALLERGY RLF 50 MCG SPR
42959	FLONASE SENSIMIST 27.5 MCG SPR
62263	FLONASE 0.05% NASAL SPRAY
34280	FLUNISOLIDE 0.025% SPRAY
62263	FLUTICASONE PROP 50MCG SPRAY
71431	MOMETASONE FUROATE 50MGCG SPRY
36145	NASACORT ALLERGY 24HR SPRAY
01211	NASACORT NASAL INHALER
01214	NASACORT AQ NASAL SPRAY
71431	NASONEX 50 MCG NASAL SPRAY
52083	NASONEX 24HR ALLERGY 50MCG SPR
97453	OMNARIS 50 MCG NASAL SPRAY
37654	QNASL CHILDRENS 40MCG SPRAY
31769	QNASL 80MCG NASAL SPRAY
92231	RHINOCORT AQUA NASAL SPRAY
62998	RHINOCORT NASAL INHALER
40708	RHINOCORT ALLERGY 32 MCG SPRAY

Intranasal Corticosteroid (INC)	
GCN	Label Name
49205	RYALTRIS 665-25MCG SPRAY
36145	TRIAMCINOLONE 55MCG NASAL SPRAY
43878	XHANCE 93MCG NASAL SPRAY

LABA, LTM, LAMA, or Theophylline	
GCN	Label Name
50584	ADVAIR 100-50 DISKUS
50594	ADVAIR 250-50 DISKUS
50604	ADVAIR 500-50 DISKUS
97135	ADVAIR HFA 45-21 MCG INHALER
97136	ADVAIR HFA 115-21 MCG INHALER
97137	ADVAIR HFA 230-21 MCG INHALER
42956	AIRDUO RESPICLICK 55-14 MCG
42957	AIRDUO RESPICLICK 113-14 MCG
42958	AIRDUO RESPICLICK 232-14 MCG
35903	ANORO ELLIPTA 62.5-25 MCG INH
41199	BEVESPI AEROSPHERE INHALER
54747	BREO ELLIPTA 50-25 MCG INHALER
34647	BREO ELLIPTA 100-25 MCG INHALR
35808	BREO ELLIPTA 200-25 MCG INHALR
98499	BREYNA 80-4.5 MCG INHALER
98500	BREYNA 160-4.5 MCG INHALER
98499	BUDESONIDE-FORMOTEROL 80-4.5
98500	BUDESONIDE-FORMOTEROL 160-4.5

LABA, LTM, LAMA, or Theophylline	
GCN	Label Name
37735	DUAKLIR PRESSAIR 400-12MCG INH
30139	DULERA 50 MCG-5 MCG INHALER
28766	DULERA 100 MCG-5 MCG INHALER
28767	DULERA 200 MCG-5 MCG INHALER
97135	FLUTICASONE-SALMETEROL 45-21
42956	FLUTICASONE-SALMETEROL 55-14
50584	FLUTICASONE-SALMETEROL 100-50
42957	FLUTICASONE-SALMETEROL 113-14
97136	FLUTICASONE-SALMETEROL 115-21
97137	FLUTICASONE-SALMETEROL 230-21
42958	FLUTICASONE-SALMETEROL 232-14
50594	FLUTICASONE-SALMETEROL 250-50
50604	FLUTICASONE-SALMETEROL 500-50
34647	FLUTICASONE-VILANTEROL 100-25
35808	FLUTICASONE-VILANTEROL 200-25
36574	INCRUSE ELLIPTA 62.5 MCG INH
44206	LONHALA MAGNAIR 25 MCG STARTER
44209	LONHALA MAGNAIR 25 MCG REFILL
94444	MONTELUKAST SOD 10MG TABLET
18803	MONTELUKAST SOD 4MG GRANULES
42373	MONTELUKAST SOD 4MG TAB CHEW
94440	MONTELUKAST SOD 5MG TAB CHEW
64012	SEREVENT DISKUS 50MCG
94444	SINGULAIR 10MG TABLET

LABA, LTM, LAMA, or Theophylline	
GCN	Label Name
18803	SINGULAIR 4MG GRANULES
42373	SINGULAIR 4MG TABLET CHEW
94440	SINGULAIR 5MG TABLET CHEW
17853	SPIRIVA 18 MCG CP-HANDIHALER
39587	SPIRIVA RESPIMAT 1.25 MCG INH
98921	SPIRIVA RESPIMAT 2.5 MCG INH
38687	STIOLTO RESPIMAT INHAL SPRAY
98499	SYMBICORT 80-4.5 MCG INHALER
98500	SYMBICORT 160-4.5 MCG INHALER
00324	THEO-24 ER 100 MG CAPSULE
00325	THEO-24 ER 200 MG CAPSULE
00326	THEO-24 ER 300 MG CAPSULE
00323	THEO-24 ER 400 MG CAPSULE
01080	THEOPHYLLINE 80 MG/15 ML SOLN
00413	THEOPHYLLINE ER 300 MG TAB
00415	THEOPHYLLINE ER 400 MG TABLET
00416	THEOPHYLLINE ER 450 MG TAB
00417	THEOPHYLLINE ER 600 MG TABLET
43921	TRELEGY ELLIPTA 100-62.5-25
48708	TRELEGY ELLIPTA 200-62.5-25
33084	TUDORZA PRESSAIR 400 MCG INHAL
50584	WIXELA 100-50 INHUB
50594	WIXELA 250-50 INHUB
50604	WIXELA 500-50 INHUB

LABA, LTM, LAMA, or Theophylline	
GCN	Label Name
52271	ZAFIRLUKAST 10MG TABLET
18690	ZAFIRLUKAST 20MG TABLET
98822	ZILEUTON ER 600MG TABLET
98822	ZYFLO CR 600MG TABLET

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 Corticosteroids	
GCN	Label Name
31490	AMCINONIDE 0.1% CREAM
31560	AMCINONIDE 0.1% LOTION
67730	APEXICON E 0.05% CREAM
31060	BETAMETHASONE DP 0.05% CRM
31080	BETAMETHASONE DP 0.05% LOT
31070	BETAMETHASONE DP 0.05% OINT

Topical Corticosteroids	
GCN	Label Name
31890	BETAMETHASONE DP AUG 0.05% CRM
32091	BETAMETHASONE DP AUG 0.05% GEL
30980	BETAMETHASONE DP AUG 0.05% LOT
31910	BETAMETHASONE DP AUG 0.05% OIN
31101	BETAMETHASONE VA 0.1% CREAM
32052	BETAMETHASONE VALER 0.12% FOAM
31120	BETAMETHASONE VA 0.1% LOTION
31110	BETAMETHASONE VALER 0.1% OINTM
31120	BETA-VAL 0.1% LOTION
32140	CLOBETASOL 0.05% CREAM
15892	CLOBETASOL 0.05% GEL
32130	CLOBETASOL 0.05% OINTMENT
15891	CLOBETASOL 0.05% SOLUTION
34141	CLOBETASOL EMOLLIENT 0.05% CRM
89743	CLOBETASOL PROP 0.05% FOAM
25909	CLOBEX 0.05% SPRAY
34040	CLOBEX 0.05% TOPICAL LOTION
15891	CORMAX 0.05% SOLUTION
31180	DESOXIMETASONE 0.05% CREAM
06120	DESOXIMETASONE 0.05% GEL
31181	DESOXIMETASONE 0.25% CREAM
30800	DESOXIMETASONE 0.25% OINTMENT
31470	DIFLORASONE 0.05% CREAM
31480	DIFLORASONE 0.05% OINTMENT

Topical Corticosteroids	
GCN	Label Name
30980	DIPROLENE 0.05% LOTION
31890	DIPROLENE AF 0.05% CREAM
31910	DIPROLENE 0.05% OINTMENT
31890	DIPROLENE AF 0.05% CREAM
31390	FLUOCINONIDE 0.05% CREAM
31380	FLUOCINONIDE 0.05% GEL
31400	FLUOCINONIDE 0.05% OINTMENT
31401	FLUOCINONIDE 0.05% SOLUTION
54650	FLUOCINONIDE-E 0.05% CREAM
54650	FLUOCINONIDE-EMOL 0.05% CREAM
24306	FLUOCINONIDE 0.1% CREAM
31251	HALOBETASOL PROP 0.05% CREAM
31211	HALOBETASOL PROP 0.05% OINTMNT
31441	HALOG 0.1% CREAM
31451	HALOG 0.1% OINTMENT
89743	OLUX 0.05% FOAM
97649	OLUX-E 0.05% FOAM
40655	SERNIVO 0.05% SPRAY
32140	TEMOVATE 0.05% CREAM
32130	TEMOVATE 0.05% OINTMENT
06120	TOPICORT 0.05% GEL
31181	TOPICORT 0.25% CREAM
30800	TOPICORT 0.25% OINTMENT
31180	TOPICORT LP 0.05% CREAM

Topical Corticosteroids	
GCN	Label Name
34545	TOPICORT 0.25% SPRAY
31231	TRIAMCINOLONE 0.025% CREAM
31260	TRIAMCINOLONE 0.025% LOTION
31241	TRIAMCINOLONE 0.025% OINT
31232	TRIAMCINOLONE 0.1% CREAM
31261	TRIAMCINOLONE 0.1% LOTION
31242	TRIAMCINOLONE 0.1% OINTMENT
31233	TRIAMCINOLONE 0.5% CREAM
31244	TRIAMCINOLONE 0.5% OINTMENT
31243	TRIANEX 0.05% OINTMENT
31251	ULTRAVATE 0.05% CREAM
24306	VANOS 0.1% CREAM

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	Every 2 weeks	300	225	225	300	375					
>700-800		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	Every 2 weeks	450	600	375	450	450	525		
>700-800		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	[Redacted]
>1300-1500		525	600	

**Monoclonal Antibody Agents****Clinical Criteria References**

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9. Fasenra Prescribing Information. Wilmington, DE. AstraZeneca Pharmaceuticals LP. September 2024.
10. Nucala Prescribing Information. Philadelphia, PA. GlaxoSmithKline LLC. June 2025.
11. Tezspire Prescribing Information. Thousand Oaks, CA. Amgen Inc. October 2025.
12. Ebglyss Prescribing Information. Indianapolis, IN. Eli Lilly and Company. May 2025.
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Monoclonal Antibody Agents

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	<ul style="list-style-type: none"> Initial publication and presentation to DUR Board
05/26/2020	<ul style="list-style-type: none"> Removed GCN for Fasenra syringe
02/01/2021	<ul style="list-style-type: none"> Updated Fasenra criteria: <ul style="list-style-type: none"> 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: <ul style="list-style-type: none"> Added diagnosis of hypereosinophilic syndrome (HES) and age check to criteria logic and logic diagram Added HES diagnosis table Updated references
06/08/2021	<ul style="list-style-type: none"> Updated Nucala criteria: <ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> Updated Nucala criteria: <ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> Combined Dupixent clinical criteria guide with Monoclonal Antibody clinical criteria guide Added criteria for Adbry as approved by the DUR Board
05/31/2022	<ul style="list-style-type: none"> Added GCN for Dupixent (51385) to PA table Added diagnosis of eosinophilic esophagitis for clients ≥ 12 years of age for Dupixent

Publication Date	Notes
06/09/2022	<ul style="list-style-type: none"> Updated age to ≥ 6 months for Dupixent for patients with atopic dermatitis
06/13/2022	<ul style="list-style-type: none"> Updated age to ≥ 6 years for Nucala for patients with asthma
07/25/2022	<ul style="list-style-type: none"> Added criteria for Xolair as approved by the DUR Board on July 22, 2022
08/10/2022	<ul style="list-style-type: none"> Added pimecrolimus and tacrolimus (topical) as prior therapy for Dupixent when using to treat atopic dermatitis
10/28/2022	<ul style="list-style-type: none"> Added diagnosis of prurigo nodularis for clients ≥ 18 years of age for Dupixent Removed ICD-10 codes for unspecified asthma
03/23/2023	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> Updated age for Adbry to 12 years and older
02/06/2024	<ul style="list-style-type: none"> Dupixent – updated age for eosinophilic esophagitis to 1 year and older with weight greater than or equal to 15 kg
03/12/2024	<ul style="list-style-type: none"> Dupixent – updated step 4 (Is the client ≥ 6 years of age?); from ‘if no, deny’ to ‘no, go to step 7’
04/02/2024	<ul style="list-style-type: none"> Xolair – added diagnosis of IgE-mediated food allergy for clients 1 year and older
05/07/2024	<ul style="list-style-type: none"> Fasenra – added indication for eosinophilic asthma and updated age to ≥ 6 years of age

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05/09/2024	<ul style="list-style-type: none"> Added GCN for Nucala (52416) to Drugs Requiring PA table and to the Duplicate Monoclonal Antibody Therapy table
05/14/2024	<ul style="list-style-type: none"> Added GCN for Fasentra (55559) to Drugs Requiring PA table and to the Duplicate Monoclonal Antibody Therapy table
08/13/2024	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> Removed GCN for Fasentra (55559) – product is for healthcare provider administration only
10/01/2024	<ul style="list-style-type: none"> Dupixent: Updated age to ≥ 12 years for the diagnosis of chronic rhinosinusitis with nasal polyps and added a diagnosis of COPD for adults Fasentra: Added a diagnosis of EGPA for adults
11/07/2024	<ul style="list-style-type: none"> Added criteria for Tezspire
01/07/2025	<ul style="list-style-type: none"> Added GCNs for Xolair (55222, 55223, 55224, 55225) to Drugs Requiring PA Table
01/31/2025	<ul style="list-style-type: none"> Added criteria for Ebglyss as approved by the DURB Board
04/30/2025	<ul style="list-style-type: none"> Annual review by staff Added a diagnosis check for bullous pemphigoid to the Dupixent criteria Added GCNs for Ivermectin (39561), Stromectol (39561), Arava (67033), azathioprine (19173, 19170), cyclophosphamide (38360, 38361), Otrexup (41774, 41007, 41008, 39393), Rasuvo (36854), Adbry (51749, 55922), Fasentra (44088, 55559), Nucala (40084), Tezspire (51748), Cetirizine (49290, 27714, 21769, 21771), Child Loratadine (45393), Clemastine (46690), Chlorpheniramine (46512, 46464, 46544, 46461, 46541, 96098, 46503), Dexchlorpheniramine (46570, 46571, 46550), Dimenhydrinate (18190, 18231), Diphenhydramine (46032, 46000, 46001, 27481, 46032, 48831, 46062), Fexofenadine (37198, 97779), Hydroxyzine (13901, 13900, 13882, 13881, 13901), Loratadine (60521), Meclizine (18301, 18302, 18312), Promethazine (52370, 52380, 52360, 15035, 15043, 15044, 15042), RA Loratadine (60563, 60521, 60562), SK-Diphenhydramine (45972), SM Loratadine (60521, 63570), SM Child Loratadine (60562), Airduo Respiclick (42956, 42957, 42958), Budesonide-Formoterol (98499, 98500), Nasonex (71431, 52083), Child Flonase (37683, 42959), Flonase (37683, 42959, 62263), Nasacort (36145, 01211, 01214), Child Nasacort (36145), Rhinocort (92231, 62998, 40708), Advair (50584, 50594, 50604, 97135, 97136, 97137), Dulera (30139, 28766, 28767), Breo (54747, 34647, 35808), Symbicort (98499,

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	<p>98500), Breyna (98499, 98500), Wixela (50584, 50594, 50604), Fluticasone-Salmeterol (97135, 42956, 50584, 42957, 97136, 97137, 42958, 50594, 50604), Fluticasone-Vilanterol (34647, 35808), Incruse (36574), Tudorza (33084), Bevespi (41199), Anoro (35903), Duaklir (37735), Stiolto (38687), and Lonhala Magnair (44209, 44206) to the supporting tables section</p> <ul style="list-style-type: none"> Removed GCNs for Airduo Digihaler (48494, 48495, 48489) from the supporting tables section – products discontinued Updated references
07/25/2025	<ul style="list-style-type: none"> Added new indication for Dupixent (chronic spontaneous urticaria) and Nucala (chronic obstructive pulmonary disease and an eosinophilic phenotype) as approved by the DUR Board
01/23/2026	<ul style="list-style-type: none"> Added new indication for the add-on maintenance treatment of adult and pediatric patients aged 12 years and older with inadequately controlled chronic rhinosinusitis with nasal polyps (CRSwNP) to Tezspire criteria Updated lookback language for past claims for asthma controller medication to “concurrent therapy with asthma controller medication” and added this check to renewal requests to Tezspire criteria Updated criteria lookback language to say, “in past medical and/or pharmacy claims history?” Updated concurrent therapy checks to say, “Will the client have concurrent therapy with...” Updated references
03/23/2026	<ul style="list-style-type: none"> Added new indication for allergic fungal rhinosinusitis (AFRS) to Dupixent criteria Removed the check in Nucala criteria for HES in clients with asthma or COPD Added ICD-10 code J8283 to the Moderate to Severe Asthma supporting table Added ICD-10 code J8289 to the Eosinophilic Asthma and Moderate to Severe Asthma supporting tables Updated references
03/30/2026	<ul style="list-style-type: none"> Updated the max quantity check for clients using Fasenera for eosinophilic granulomatosis with polyangiitis (EGPA)