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<b>NC Medicaid Outpatient Pharmacy Prior Approval Criteria Monoclonal Antibody</b>	<b>Medicaid and Health Choice Effective Date: November 1, 2011 Amended Date: June 10, 2019</b>
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**Therapeutic Class Code:** Z2L, Z2O, V4D  
**Therapeutic Class Description:** Monoclonal Antibody

Medication	Generic Code Number(s)	NDC Number(s)
Xolair	19966, 30555, 30556	
Fasenra	44088	
Nucala	40084	
Dupixent	43222, 45522	

**Eligible Beneficiaries**

NC Medicaid (Medicaid) beneficiaries shall be enrolled on the date of service and may have service restrictions due to their eligibility category that would make them ineligible for this service.

NC Health Choice (NCHC) beneficiaries, ages 6 through 18 years of age, shall be enrolled on the date of service to be eligible, and must meet policy coverage criteria, unless otherwise specified. **EPSDT does not apply to NCHC beneficiaries.**

**EPSDT Special Provision: Exception to Policy Limitations for Beneficiaries under 21 Years of Age 42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]**

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid beneficiaries under 21 years of age **if** the service is **medically necessary health care** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination (includes any evaluation by a physician or other licensed clinician). This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his/her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems. Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested

**<https://provider.healthybluenc.com>**

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by the beneficiary's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the beneficiary's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product, or procedure

- a. that is unsafe, ineffective, or experimental/investigational.
- b. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and/or other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure meets all EPSDT criteria, including to correct or improve or maintain the beneficiary's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

**EPSDT and Prior Approval Requirements**

- a. If the service, product, or procedure requires prior approval, the fact that the beneficiary is under 21 years of age does **NOT** eliminate the requirement for prior approval.
- b. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the *Basic Medicaid and NC Health Choice Billing Guide*, sections 2 and 6, and on the EPSDT provider page. The Web addresses are specified below.

***Basic Medicaid and NC Health Choice Billing Guide:***

<https://medicaid.ncdhhs.gov/>

**EPSDT provider page:** <https://medicaid.ncdhhs.gov/>

**Health Choice Special Provision: Exceptions to Policy Limitations for Health Choice Beneficiaries ages 6 through 18 years of age**

**EPSDT does not apply to NCHC beneficiaries.** If a NCHC beneficiary does not meet the clinical coverage criteria within **the Outpatient Pharmacy prior approval** clinical coverage criteria, the NCHC beneficiary shall be denied services. Only services included under the Health Choice State Plan and the NC Medicaid clinical coverage policies, service definitions, or billing codes shall be covered for NCHC beneficiaries.

**1. Xolair**

**A. Allergic Asthma:**

**Criteria for Initial Therapy of Xolair (Allergic Asthma):**

The beneficiary must meet **all** of the following criteria:

- 1) be 6 years of age and older;
- 2) have a diagnosis of asthma;
- 3) have inadequately controlled asthma meeting one of the following definitions:
  - a. Use of inhaled corticosteroids in the past 45 days and excessive use of short-acting beta agonists in the past 60 days; **OR**
  - b. Use of inhaled corticosteroids in the past 45 days and short-term oral steroid use in the past 45 days; **OR**
  - c. Use of inhaled corticosteroids in the past 45 days and an emergency room visit in the past 45 days;
- 4) A percutaneous skin test or RAST allergy test in the past twelve months indicating reactivity to at least one perennial aeroallergen;
- 5) IgE level above 30 IU/mL. Approval length up to 12 months.

**Criteria for Continuation of Therapy of Xolair (Allergic Asthma):**

For beneficiaries already receiving Xolair, coverage is provided when there is continued clinical benefit as evidenced by reductions in asthma exacerbations from baseline supported by medical records documenting the beneficiary's current asthma status, response to Xolair treatment, and current smoking status.

Approval length up to 12 months.

**B: Chronic Idiopathic Urticaria for Xolair:**

**Criteria for Initial Therapy of Xolair (Chronic Idiopathic Urticaria):**

- 1) Covered for beneficiaries 12 years of age and above with moderate to severe chronic idiopathic urticaria who remain symptomatic despite treatment with at least two H1 antihistamines and one leukotriene modifier.
- 2) Omalizumab should also be prescribed in consultation with an allergy specialist.

**Criteria for Continuation of Therapy of Xolair (Chronic Idiopathic Urticaria):**

For beneficiaries already receiving Xolair, coverage is provided when criteria for initial therapy are met and there is continued clinical benefit from baseline supported by medical records.

## **2. Fasenra**

### **A. Severe Asthma:**

#### **Criteria for Initial Therapy of Fasenra (Asthma):**

The beneficiary must meet **all** of the following criteria:

- 1) be 12 years of age and older;
  - 2) have a diagnosis of severe eosinophilic asthma;
  - 3) have a pre-treatment serum eosinophil count of 150 cells/mcL or greater at screening (within the past 6 weeks prior to the request for Fasenra) or 300 cells/mcL or greater within 12 months prior to use, or sputum eosinophilic count greater than 3%;
  - 4) have inadequate control of asthmatic symptoms after a minimum of 3 months of high dose corticosteroid inhaler in combination with a long acting beta-agonist;
  - 5) have inadequately controlled severe asthma meeting one of the following definitions:
    - a. 2 or more asthma exacerbations requiring oral/systemic corticosteroid treatment; or
    - b. hospitalization in the past 12 months;
  - 6) have prebronchodilator FEV1 below 80% in adults and 90% in adolescents;
  - 7) Fasenra is being used as add on maintenance treatment;
  - 8) Fasenra is not being used for the treatment of other eosinophilic conditions;
  - 9) Fasenra is not being used for the relief of acute bronchospasm or status asthmaticus;
  - 10) Fasenra is not being used as dual therapy with other monoclonal antibody treatments;
- and**  
Initial approval up to 6 months.

#### **Criteria for Continuation of Therapy of Fasenra (Asthma):**

For beneficiaries already receiving Fasenra, coverage is provided when criteria for initial therapy are met and there is continued clinical benefit as evidenced by reductions in asthma exacerbations from baseline supported by medical records documenting the beneficiary's current asthma status and response to Fasenra treatment

Approval length up to 12 months.

### **3. Nucala**

#### **A. Asthma**

##### **Criteria for Initial Therapy (Asthma):**

The beneficiary must meet **all** of the following criteria:

- 1) be 12 years of age or older
- 2) have a diagnosis of severe eosinophilic asthma;
- 3) have a pre-treatment serum eosinophil count of 150 cells/mcL or greater at screening (within the past six weeks prior to the request for Nucala) or 300 cells/mcL or greater within 12 months prior to use, or sputum eosinophilic count greater than 3%;
- 4) have inadequate control of asthmatic symptoms after a minimum of 3 months of high dose corticosteroid inhaler in combination with a long acting beta-agonist
- 5) have inadequately controlled severe asthma meeting one of the following definitions:
  - a. two or more asthma exacerbations requiring oral/systemic corticosteroid treatment; or
  - b. hospitalization in the past 12 months;
- 6) have prebronchodilator FEV1 below 80% in adults and 90% in adolescents;
- 7) Nucala is being used as add on maintenance treatment;
- 8) Nucala is not being used for the treatment of other eosinophilic conditions
- 9) Nucala is not being used for the relief of acute bronchospasm or status asthmaticus
- 10) Nucala is not being used as dual therapy with other monoclonal antibody treatments;

**and**

Initial approval up to 6 months.

##### **Criteria for Continued Therapy (Asthma):**

For beneficiaries already receiving Nucala, coverage is provided when criteria for initial therapy are met and there is continued clinical benefit as evidenced by reductions in asthma exacerbations from baseline supported by medical records documenting the beneficiary's current asthma status and response to Nucala treatment.

Approval length up to 12 months.

**B. Eosinophilic Granulomatosis with Polyangiitis**

**Criteria for Initial Therapy (Polyangiitis):**

The beneficiary must have the following:

- 1) Confirmed diagnosis of Eosinophilic Granulomatosis with Polyangiitis
- 2) Be 18 years old or older Approval length up to 6 months.

**Criteria for Continued Therapy (Polyangiitis):**

For beneficiaries already receiving Nucala, coverage is provided when criteria for initial therapy are met and there is continued clinical benefit from baseline supported by medical records.

Approval length up to 12 months.

**4. Dupixent**

**A. Atopic Dermatitis**

**Criteria for Initial Therapy (Atopic Dermatitis)**

The beneficiary must meet **all** of the following criteria:

1. be 18 years of age or older
2. have a diagnosis of moderate to severe Atopic Dermatitis
3. have failed at least 2 prescription topical steroids or have a documented adverse reaction or contraindication that precludes trial of at least 2 prescription topical steroids
4. have tried and failed on either Protopic, Elidel, Eucrisa, or tacrolimus or has a documented adverse reaction or contraindication that precludes trial of either Protopic, Elidel, Eucrisa or tacrolimus.

Approval length up to six months

**Criteria for Continuation of Therapy of Dupixent (Atopic Dermatitis):**

For beneficiaries already receiving Dupixent, coverage is provided when criteria for initial therapy are met and there is continued clinical benefit from baseline supported by medical records.

**B. Asthma**

**Criteria for Initial Therapy (Asthma)**

1. Beneficiary is 12 years of age or older and has **ONE** of the following:
  - a. A diagnosis of Asthma with eosinophilic phenotype with a pre-treatment serum eosinophil count of 150 cells/mcL or greater at screening (within the past six weeks prior to the request for Dupixent) or 300 cells/mcL or greater within 12 months prior to use, or sputum eosinophilic count greater than 3% **OR**
  - b. Oral corticosteroid dependent asthma with at least 1 month of daily oral corticosteroid use within the last 3 months **AND**
2. Inadequate control of asthma symptoms after a minimum of 3 months of compliant use of **ONE** of the following within the past 6 months:
  - a. Inhaled corticosteroids & long acting beta2 agonist **OR**
  - b. Inhaled corticosteroids & long acting muscarinic antagonist **AND**
3. **NOT** being used for the relief of acute bronchospasm or status asthmaticus **AND**
4. **NOT** receiving dual therapy with another monoclonal antibody for the treatment of asthma

Approval length up to six months

**Criteria for Continued Therapy (Asthma):**

For beneficiaries already receiving Dupixent, coverage is provided when criteria for initial therapy are met and there is continued clinical benefit as evidenced by reductions in asthma exacerbations from baseline supported by medical records documenting the beneficiary's current asthma status and response to Dupixent treatment.

**References**

1. Genentech, Inc. Xolair Package Insert. San Francisco, CA. September 2014.
2. Astra Zeneca, Inc. Fasenra Package Insert. Wilmington, DE. November 2017.
3. GlaxoSmithKline, LLC. Nucala Package Insert. Philadelphia, PA. November 2015, updated 12/2017
4. Regeeneron Pharmaceuticals, INC. Dupixent package insert. Tarrytown, NJ: March 2017, updated November 2018.

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**Criteria Change Log**

11/01/2011	Criteria effective date (Xolair only)
05/20/2015	Criteria amended to include Chronic Idiopathic Urticaria for Xolair
04/26/2016	Nucala criteria effective
04/05/2018	Added criteria for Fasenra
05/04/2018	Added coverage for Eosinophilic Granulomatosis with Polyangiitis for Nucala
06/01/2018	Combined Nucala with Xolair and Fasenra into 1 criteria
11/20/2018	Add continuation criteria for Xolair for Idiopathic Urticaria and Nucala for Granulomatosis Polyangiitis, change eosinophilic count to 150 cells/mcl for Fasenra and Nucala.
06/10/2019	Added Dupixent to monoclonal antibody criteria and added additional criteria for Dupixent for Asthma diagnosis. Added 2 new GCN's for Xolair.