Policy Number	**RX501.080**
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Mepolizumab

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Related Policies (if applicable)
None

Disclaimer

Medical policies are a set of written guidelines that support current standards of practice. They are based on current generally accepted standards of and developed by nonprofit professional association(s) for the relevant clinical specialty, third-party entities that develop treatment criteria, or other federal or state governmental agencies. A requested therapy must be proven effective for the relevant diagnosis or procedure. For drug therapy, the proposed dose, frequency and duration of therapy must be consistent with recommendations in at least one authoritative source. This medical policy is supported by FDA-approved labeling and/or nationally recognized authoritative references to major drug compendia, peer reviewed scientific literature and generally accepted standards of medical care. These references include, but are not limited to: MCG care guidelines, DrugDex (IIa level of evidence or higher), NCCN Guidelines (IIb level of evidence or higher), NCCN Compendia (IIb level of evidence or higher), professional society guidelines, and CMS coverage policy.

Carefully check state regulations and/or the member contract.

Each benefit plan, summary plan description or contract defines which services are covered, which services are excluded, and which services are subject to dollar caps or other limitations, conditions or exclusions. Members and their providers have the responsibility for consulting the member's benefit plan, summary plan description or contract to determine if there are any exclusions or other benefit limitations applicable to this service or supply. **If there is a discrepancy between a Medical Policy and a member's benefit plan, summary plan description or contract, the benefit plan, summary plan description or contract will govern.**

Legislative Mandates

EXCEPTION: For members residing in the state of Ohio**,** § 3923.60 requires any group or individual policy (Small, Mid-Market, Large Groups, Municipalities/Counties/Schools, State Employees, Fully-Insured, PPO, HMO, POS, EPO) that covers prescription drugs to provide for the coverage of any drug approved by the U. S. Food and Drug Administration (FDA) when it is prescribed for a use recognized as safe and effective for the treatment of a given indication in one or more of the standard medical reference compendia adopted by the United States Department of Health and Human Services or in medical literature even if the FDA has not approved the drug for that indication. Medical literature support is only satisfied when safety and efficacy has been confirmed in two articles from major peer-reviewed professional medical journals that present data supporting the proposed off-label use or uses as generally safe and effective. Examples of accepted journals include, but are not limited to, Journal of

American Medical Association (JAMA), New England Journal of Medicine (NEJM), and Lancet. Accepted study designs may include, but are not limited to, randomized, double blind, placebo controlled clinical trials. Evidence limited to case studies or case series is not sufficient to meet the standard of this criterion. Coverage is never required where the FDA has recognized a use to be contraindicated, and coverage is not required for non-formulary drugs.

Coverage

NOTE 1: Mepolizumab (Nucala®) may be self-administered (see Policy Guidelines). For self-administered medications, please refer to the applicable pharmacy benefit plan.

Eosinophilic Asthma

Mepolizumab (Nucala®) **may be considered medically necessary** for the add-on maintenance treatment of severe eosinophilic asthma when the following criteria are met:

- Individual is 6 years of age or older; AND
- There is documented and current use of an inhaled corticosteroid (ICS) in combination with a long acting beta2-agonist (LABA), leukotriene receptor antagonist [LTRA], theophylline or long-acting muscarinic antagonist (LAMA); AND
- The individual has uncontrolled asthma while on control therapy as evidenced by 2 or more exacerbations requiring systemic glucocorticoids, frequent ER visits, or hospitalizations (see **NOTE 2**); AND
- Eosinophil count of the following:
  - 150 cells/µL or more in peripheral blood at screening; or
  - 300 cells/µL or more during the previous year.

NOTE 2: Individuals who do not meet the criteria for uncontrolled asthma, but whose asthma worsens on tapering off corticosteroids, will also meet this definition of moderate to severe asthma. For definition of uncontrolled asthma see Description section.

Eosinophilic Chronic Obstructive Pulmonary Disease (COPD)

Mepolizumab (Nucala®) **may be considered medically necessary** as add-on maintenance treatment of inadequately controlled chronic obstructive pulmonary disease of an eosinophilic phenotype when the following criteria are met:

- Individual is 18 years of age or older; AND
- Post-bronchodilator forced expiratory volume in 1 second (FEV_1)/forced vital capacity (FVC) ratio of <0.7 and post-bronchodilator FEV_1 of 20% to 80% predicted; AND
- Documentation of at least 2 moderate or 1 severe COPD exacerbation(s) in the previous year despite receiving triple inhaled therapy; AND
- Blood eosinophil count ≥150 cell/mcL at screening or ≥300 cell/mcL in the previous 12 months.

Hypereosinophilic Syndrome

Mepolizumab (Nucala®) **may be considered medically necessary** for the treatment of hypereosinophilic syndrome (HES) when the following criteria are met:

- Individual is 12 years of age or older; AND
- Individual is ≥ 6 months of age without an identifiable non-hematologic HES or FIP1L1-PDGFRα kinase-positive HES; AND
- History of 2 or more HES flares within the past 12 months; AND
- Blood eosinophil count of 1,000 cells/mcL or higher at screening.

NOTE 3: An HES flare is defined as HES-related worsening of clinical symptoms or increasing blood eosinophil counts (on at least 2 occasions) requiring an escalation in therapy (HES therapy could include chronic or episodic oral corticosteroids [OCS], immunosuppressive, or cytotoxic therapy).

NOTE 4: Non-hematologic HES may include drug hypersensitivity, parasitic helminth infection, human immunodeficiency virus (HIV) infection, or non-hematologic malignancy.

Eosinophilic Granulomatosis with Polyangiitis

Mepolizumab (Nucala®) **may be considered medically necessary** for individuals 18 years and older for the treatment of relapsing or refractory eosinophilic granulomatosis with polyangiitis (EGPA) (Churg-Strauss syndrome).

Chronic Rhinosinusitis with Nasal Polyps

Mepolizumab (Nucala®) **may be considered medically necessary** for the add-on maintenance treatment of chronic rhinosinusitis with nasal polyps (CRSwNP) when the following criteria are met:

- Individual is 18 years of age or older; AND
- Confirmation of diagnosis by one of the following:
  - Anterior rhinoscopy or endoscopy; or
  - Computed tomography (CT) of the sinuses; AND
- Inadequate response, intolerance, or contraindication to intranasal corticosteroids; AND
- Will be used in combination with standard nasal polyp maintenance therapy (e.g., nasal saline irrigation, intranasal corticosteroids).

Mepolizumab (Nucala®) **is considered experimental, investigational and/or unproven** for all other non-Food and Drug Administration (FDA) approved indications.

Policy Guidelines

Nucala is not indicated for the relief of acute bronchospasm or status asthmaticus.

Self-Administration

- Not applicable to plans regulated by the Illinois Department of Insurance, Medicare, or Medicaid plans.

- The U.S. Food and Drug Administration (FDA) has deemed the drug(s) or biological product(s) in this medical policy may be appropriate for self-administration or for administration by a caregiver (i.e., not a healthcare professional).

Description

Asthma

Asthma affects about 300 million people worldwide and more than 28 million in the United States. (3) In most cases, it can be effectively controlled with standard treatment that includes short-acting β2-agonists, long-acting β2-agonists (LABA), inhaled corticosteroids (ICSs), oral corticosteroids, and omalizumab if allergies present. However, 5% to 10% of patients suffer from severe or refractory asthma who cannot achieve control with standard treatment.

Much remains unclear about the best approaches to managing severe asthma and specifically eosinophilic asthma. Patients with eosinophilic asthma are generally responsive to corticosteroid therapy and are at an increased risk of exacerbation after corticosteroid withdrawal. In contrast, non–eosinophilic asthma is associated with a significantly poorer response to treatment with ICSs. New treatments, particularly monoclonal antibodies currently being developed, target specific pathophysiologic mechanisms, and therefore must be tailored to each patient to match the disease heterogeneity.

Definition of Uncontrolled Asthma

At least one of the following:

- Asthma Control Questionnaire (ACQ) score consistently >1.5, Asthma Control Test (ACT) score <20 (or ‘‘not well controlled’’ by National Asthma Education and Prevention Program [NAEPP]/Global Initiative for Asthma [GINA] guidelines);
- Frequent severe exacerbations: ≥2 bursts of systemic corticosteroids (CS) (>3 days each) in the previous year;
- Serious exacerbations: at least 1 hospitalization, ICU stay, or mechanical ventilation in the previous year;
- Airflow limitation: after appropriate bronchodilator withhold, forced expiratory volume in 1 second (FEV_1) <80% predicted (in the face of reduced FEV_1/forced vital capacity (FVC) defined as less than the lower limit of normal). (4)

Eosinophilic Granulomatosis with Polyangiitis

Eosinophilic granulomatosis with polyangiitis (EGPA), previously called the Churg-Strauss syndrome or allergic granulomatosis and angiitis, is a multisystem disorder characterized most commonly by asthma/obstructive lung disease, rhinitis, nasal polyps, and prominent peripheral blood and tissue eosinophilia. EGPA is classified as a vasculitis of the small- and medium-sized arteries, although the vasculitis, when present, may be difficult to diagnose depending on the ability to obtain biopsies off treatment or in locations where affected vessels can be obtained. Other than the allergic manifestations, the most commonly involved organs are the lungs, the skin, and the peripheral nervous system. However, EGPA can affect almost any organ system,

including the cardiovascular, gastrointestinal, kidney, and central nervous systems. Asthma is the cardinal clinical feature of EGPA, present in more than 90 percent of patients. Asthma usually precedes frank vasculitis by approximately 8 to 10 years. Vasculitis of extrapulmonary organs can result in significant morbidity and mortality. (5)

Hypereosinophilic Syndrome

Hypereosinophilic syndrome (HES) is a group of rare blood disorders. It occurs when an individual's blood has very high numbers of eosinophils. (6) An eosinophil is a type of white blood cell that plays an important role in the immune system. These eosinophils make their way into various tissues, causing inflammation and eventually organ dysfunction. The most commonly involved organs in HES include the skin, lungs, heart and nervous system. The goal of HES treatment is to reduce eosinophil levels in the blood and tissues, thereby preventing tissue damage–especially in the heart. Standard HES treatment includes glucocorticosteroid medications such as prednisone, and chemotherapeutic agents such as hydroxyurea, chlorambucil and vincristine. Interferon-alpha may also be used as a treatment. This medication must be administered by frequent injections. The prognosis of HES depends upon the extent of any organ damage. Although survival rates have improved significantly, HES may be fatal in very severe cases. In 1975, only 12% of HES patients survived three years. Today, more than 80% of HES patients survive five years or more. (6)

Chronic Rhinosinusitis

Chronic rhinosinusitis (CRS) can be broadly defined as an inflammatory disorder of the paranasal sinuses and linings of the nasal passages that lasts 12 weeks or longer. Cardinal signs and symptoms of CRS in adults include anterior and/or posterior nasal mucopurulent drainage; nasal obstruction, blockage, or congestion; facial pain, pressure and/or fullness; and reduction or loss of sense of smell. About 18%-30% of cases include nasal polyposis and is characterized by a gradual worsening of nasal congestion/obstruction, sinus fullness and pressure, fatigue, posterior nasal drainage, and partial or complete loss of sense of smell. Physical examination shows the presence of bilateral nasal polyps in the middle meatus. Nasal polyps are translucent, yellowish-gray to white, glistening masses composed of gelatinous inflammatory material, which may form in the nasal cavity or paranasal sinuses. Asthma is more strongly associated with chronic rhinosinusitis with nasal polyposis than CRS without nasal polyposis. (7)

Chronic Obstructive Pulmonary Disease

Chronic obstructive pulmonary disease (COPD) is a long-term respiratory condition that gets worse over time. COPD prevents airflow to the lungs, causing breathing problems. The most common types are emphysema and chronic bronchitis. There is no cure for COPD, but it can be treated, often requiring several different medications to control it, such as bronchodilators (short-acting or long-acting), corticosteroids, mucolytics, or antibiotics. It is a leading cause of death in the United States with nearly 16 million adults having COPD and many more that do not know they have it. Tobacco smoke is the main cause of COPD, but nonsmokers can get it. (8)

Mepolizumab (Nucala)

Nucala works by reducing levels of eosinophils in the blood. Eosinophils are a type of white blood cell that are involved in inflammation. The mechanism of action of Nucala involves targeting and preventing the immune system protein interleukin-5 (IL-5) from interacting to its receptor on the surface of eosinophils, reducing eosinophil levels and inflammation. (2)

Regulatory Status (2)

- On November 4, 2015, the U. S. Food and Drug Administration (FDA) approved Nucala® as an add-on maintenance therapy for patients aged 12 years or older who have severe eosinophilic asthma with a history of exacerbations.
- On December 12, 2017, the FDA revised their label to include the indication of EGPA.
- On September 12, 2019, the FDA approved Nucala for 6- to 11-year-old children with severe eosinophilic asthma.
- On September 25, 2020, the FDA approved Nucala as the first and only biologic treatment for hypereosinophilic syndrome (HES).
- On July 29, 2021, the FDA approved Nucala for use in adults with chronic rhinosinusitis with nasal polyps.
- On May 22, 2025, the FDA approved Nucala for use in adults with eosinophilic chronic obstructive pulmonary disease (COPD).

Rationale

This policy is based on the U.S. Food and Drug Administration (FDA) labeled indications for mepolizumab (Nucala) and a review of relevant professional guidelines and position statements.

Mepolizumab (Nucala®) (1)

Severe Asthma

The asthma development program for Nucala in patients aged 12 years and older included 3 double-blind, randomized, placebo-controlled trials: 1 dose-ranging and exacerbation trial (DREAM, NCT01000506) and 2 confirmatory trials (MENSA, NCT01691521 and SIRIUS, NCT01691508). Mepolizumab was administered every 4 weeks in all 3 trials as add-on to background treatment. All patients continued their background asthma therapy throughout the duration of the trials.

Dose-Ranging and Exacerbation Trial (DREAM)

DREAM was a 52-week dose-ranging and exacerbation-reduction trial in patients with severe asthma with a history of 2 or more exacerbations in the previous year despite regular use of high-dose inhaled corticosteroids (ICS) plus additional controller(s) with or without oral corticosteroids (OCS). Patients enrolled in this trial were required to have at least 1 of the following 4 pre-specified criteria in the previous 12 months: blood eosinophil count ≥300 cells/mcL, sputum eosinophil count ≥3%, exhaled nitric oxide concentration ≥50 ppb, or deterioration of asthma control after ≤25% reduction in regular maintenance ICS/OCS. Three intravenous dosages of mepolizumab (75, 250, and 750 mg) administered once every 4 weeks were evaluated compared with placebo. Results from this trial and the pharmacodynamic study

supported the evaluation of mepolizumab 75 mg intravenously and 100 mg subcutaneously in the subsequent trials. Nucala is not indicated for intravenous use and should only be administered by the subcutaneous route.

Confirmatory Trials
A total of 711 patients with severe asthma were studied in the 2 confirmatory trials (MENSA and SIRIUS). In these 2 trials patients were required to have blood eosinophils of ≥150 cells/mcL at screening (within 6 weeks of dosing) or blood eosinophils of ≥300 cells/mcL within 12 months of enrollment. The screening blood eosinophils of ≥150 cells/mcL criterion was derived from exploratory analyses of data from the DREAM Trial. MENSA was a 32-week placebo- and active-controlled trial in patients with severe asthma with a history of 2 or more exacerbations in the previous year despite regular use of high-dose ICS plus additional controller(s) with or without OCS. Patients received mepolizumab 75 mg intravenously (n=191), Nucala 100 mg (n=194), or placebo (n=191) once every 4 weeks for 32 weeks.

SIRIUS was a 24-week OCS-reduction trial in patients with severe asthma who required daily OCS in addition to regular use of high-dose ICS plus additional controller(s) to maintain asthma control. Patients in the SIRIUS Trial were not required to have a history of exacerbations in the previous year. Patients received Nucala 100 mg (n=69) or placebo (n=66) once every 4 weeks for 24 weeks. The baseline mean OCS use was similar in the 2 treatment groups: 13.2 mg in the placebo group and 12.4 mg in the group receiving Nucala 100 mg.

Exacerbations
Efficacy was assessed in DREAM and MENSA using an endpoint of the frequency of exacerbations defined as worsening of asthma requiring use of oral/systemic corticosteroids and/or hospitalization and/or emergency department visits. For patients on maintenance OCS, an exacerbation requiring OCS was defined as the use of oral/systemic corticosteroids at least double the existing dose for at least 3 days. Compared with placebo, patients receiving Nucala 100 mg or mepolizumab 75 mg intravenously experienced significantly fewer exacerbations. Additionally, compared with placebo, there were fewer exacerbations requiring hospitalization and/or emergency department visits and exacerbations requiring only in-patient hospitalization with Nucala 100 mg (Table 1).

Table 1. Rate of Exacerbations in Severe Asthma Trials DREAM and MENSA (Intent-to-Treat Population)

Trial	**Treatment**	**Exacerbations per Year**		
		Rate	**Difference**	**Rate Ratio (95% CI)**
All exacerbations				
DREAM	Placebo (n = 155)	2.40		
	Mepolizumab 75 mg IV (n = 153)	1.24	1.16	0.52 (0.39, 0.69)
MENSA	Placebo (n = 191)	1.74		

	Mepolizumab 75 mg IV (n = 191)	0.93	0.81	0.53 (0.40, 0.72)
	Nucala 100 mg SC (n = 194)	0.83	0.91	0.47 (0.35, 0.64)
Exacerbations requiring hospitalization/emergency room visit				
DREAM	Placebo (n = 155)	0.43		
	Mepolizumab 75 mg IV (n = 153)	0.17	0.26	0.40 (0.19, 0.81)
MENSA	Placebo (n = 191)	0.20		
	Mepolizumab 75 mg IV (n = 191)	0.14	0.06	0.68 (0.33, 1.41)
	Nucala 100 mg SC (n = 194)	0.08	0.12	0.39 (0.18, 0.83)
Exacerbations requiring hospitalization				
DREAM	Placebo (n = 155)	0.18		
	Mepolizumab 75 mg IV (n = 153)	0.11	0.07	0.61 (0.28, 1.33)
MENSA	Placebo (n = 191)	0.10		
	Mepolizumab 75 mg IV (n = 191)	0.06	0.04	0.61 (0.23, 1.66)
	Nucala 100 mg SC (n = 194)	0.03	0.07	0.31 (0.11, 0.91)

CI: confidence interval; IV: intravenous; SC: subcutaneous; mg: milligram.

The time to first exacerbation was longer for the groups receiving Nucala 100 mg and mepolizumab 75 mg intravenously compared with placebo in MENSA.

DREAM data were explored to determine criteria that could identify patients likely to benefit from treatment with Nucala. The exploratory analysis suggested that baseline blood eosinophil count of ≥150 cells/mcL was a potential predictor of treatment benefit. Exploratory analysis of MENSA data also suggested that baseline blood eosinophil count (obtained within 6 weeks of initiation of dosing) of ≥150 cells/mcL was a potential predictor of efficacy and showed a trend of greater exacerbation benefit with increasing blood eosinophil count. In MENSA, patients enrolled solely on the basis of the historical blood eosinophil count of ≥300 cells/mcL in the previous 12 months, but who had a baseline blood eosinophil count <150 cells/mcL, had virtually no exacerbation benefit following treatment with Nucala 100 mg compared with placebo.

The Asthma Control Questionnaire-5 (ACQ-5) was assessed in Trials DREAM and MENSA, and the St. George's Respiratory Questionnaire (SGRQ) was assessed in MENSA. In DREAM, the ACQ-5 responder rate (defined as a decrease in score of 0.5 or more as threshold) for the 75 mg intravenous mepolizumab arm was 47% compared with 50% for placebo with an odds ratio (OR) of 1.1 (95% confidence interval [CI]: 0.7, 1.7). In MENSA, the ACQ-5 responder rate for the

treatment arm for Nucala 100 mg was 57% compared with 45% for placebo with an OR of 1.8 (95% CI: 1.2, 2.8). In MENSA, the SGRQ responder rate (defined as a decrease in score of 4 or more as threshold) for the treatment arm for Nucala 100 mg was 71% compared with 55% for placebo with an OR of 2.1 (95% CI: 1.3, 3.2).

Oral Corticosteroid Reduction

Severe Asthma Trial SIRIUS evaluated the effect of Nucala 100 mg on reducing the use of maintenance OCS. Efficacy was assessed using an endpoint of the percent reduction of OCS dose during Weeks 20 to 24 compared with baseline dose, while maintaining asthma control. Patients were classified according to their change in OCS use during the trial with the following categories: 90% to 100% decrease, 75% to <90% decrease, 50% to <75% decrease, >0% to <50% decrease, and no improvement (i.e., no change or any increase or lack of asthma control or withdrawal of treatment). Compared with placebo, patients receiving Nucala 100 mg achieved greater reductions in daily maintenance OCS dose, while maintaining asthma control. Sixteen (23%) patients in the group receiving Nucala 100 mg versus 7 (11%) in the placebo group had a 90% to 100% reduction in their OCS dose. Twenty-five (36%) patients in the group receiving Nucala 100 mg versus 37 (56%) in the placebo group were classified as having no improvement for OCS dose. Additionally, 54% of patients receiving Nucala 100 mg achieved at least a 50% reduction in the daily prednisone dose compared with 33% of patients receiving placebo (95% CI for difference: 4%, 37%). An exploratory analysis was also performed on the subgroup of 29 patients in SIRIUS who had an average baseline and screening blood eosinophil count <150 cells/mcL. Five (29%) patients in the group receiving Nucala 100 mg versus 0 (0%) in the placebo group had a 90% to 100% reduction in their dose. Four (24%) patients in the group receiving Nucala 100 mg versus 8 (67%) in the placebo group were classified as having no improvement for OCS dose. The ACQ and SGRQ were also assessed in SIRIUS and showed results similar to those in MENSA.

Lung Function

Change from baseline in mean forced expiratory volume in 1 second (FEV_1) was measured in all 3 trials and is presented in Table 2. Compared with placebo, Nucala 100 mg did not provide consistent improvements in mean change from baseline in FEV_1.

Table 2. Change from Baseline in FEV_1 (mL) in Severe Asthma Trials

Trial	Difference from Placebo in Mean Change from Baseline FEV_1 (mL) (95% CI)		
	Week 12	*Week 24*	*Weeks 32/52*
DREAM[a]	10 (-87, 108)	5 (-98, 108)	61 (-39, 161)[b]
MENSA[c]	52 (-30, 134)	76 (-6, 159)	98 (11, 184)[d]
SIRIUS[c]	56 (-91, 203)	114 (-42, 271)	NA

FEV_1: forced expiratory volume in 1 second; CI: confidence interval; NA: not applicable.

[a] Dose = 75 mg intravenous.

[b] FEV_1 at Week 52.

[c] Dose = 100 mg subcutaneous.

[d] FEV_1 at Week 32.

The effect of mepolizumab on lung function was also studied in a 12-week placebo-controlled trial enrolling patients with asthma on a moderate dose of ICS with evidence of symptoms and lung function impairment. Enrollment was not dependent on a history of exacerbations or a pre-specified eosinophil count. Change from baseline in FEV_1 at Week 12 was numerically lower in the mepolizumab treatment groups than the placebo group.

Chronic Rhinosinusitis with Nasal Polyps (CRSwNP) (1)

A total of 407 adult patients with CRSwNP were evaluated in a randomized, double-blind, placebo-controlled, multicenter, 52-week trial (NCT03085797). Patients received Nucala 100 mg or placebo administered subcutaneously once every 4 weeks while continuing nasal corticosteroid therapy. Patients must have received background nasal corticosteroid for ≥8 weeks pre-screening. Patients had recurrent and symptomatic CRSwNP and had at least 1 surgery for the removal of nasal polyps within the previous 10 years. Patients were required to have nasal obstruction symptoms with a visual analog scale (VAS) score of >5 out of a maximum score of 10. Patients were also required to have an endoscopic bilateral nasal polyp score (NPS) of ≥5 out of 8 with NPS ≥2 in each nasal cavity. Patients reported nasal obstruction VAS scores daily by placing a single mark on a continuous line labeled from 0 (none) to 100 (as bad as you can imagine). The distance along the line was converted to a 0-to-10-point scale for scoring. For NPS, polyps on each side of the nose were graded on a categorical scale (0 = no polyps, 1 = small polyps in the middle meatus not reaching below the inferior border of the middle concha, 2 = polyps reaching below the lower border of the middle turbinate, 3 = large polyps reaching the lower border of the inferior turbinate or polyps medial to the middle concha, 4 = large polyps causing almost complete congestion/obstruction of the inferior meatus) for a total score of 0 to 8. Sinus CT scans were not performed at baseline nor during treatment to evaluate for sinus opacification.

The co-primary endpoints were change from baseline to Week 52 in total endoscopic NPS (0 to 8 scale) as graded by independent blinded assessors and change from baseline in nasal obstruction VAS score (0 to 10 scale) during Weeks 49 to 52. The key secondary endpoint was the time to first nasal surgery (nasal polypectomy) up to Week 52 in this trial. Other secondary endpoints were change from baseline in loss of smell VAS score during Weeks 49 to 52, and proportion of patients requiring systemic steroids for nasal polyps up to Week 52. All VAS scores were collected daily by the patients and reported on a 0 to 10 scale (0 = none, 10 = as bad as you can imagine).

Endoscopic Nasal Polyp Score and Nasal Obstruction Visual Analog Scale Scores

Patients who received Nucala 100 mg had a statistically significant improvement (decrease) in bilateral NPS at Week 52 and nasal obstruction VAS score from Weeks 49 to 52 at the end of the 52-week treatment period (Table 3).

Table 3. Analyses of Endpoints in Chronic Rhinosinusitis with Nasal Polyps

Scores[a] (range)	Placebo n=201		Nucala 100 mg n=206		Mean Difference vs. Placebo
	Baseline Mean	Mean Change[b]	Baseline Mean	Mean Change[b]	

	(SD)	(SE)	(SD)	(SE)	(95% CI)
NPS (0-8)	5.6 (1.41)	0.06 (0.14)	5.4 (1.17)	-0.87 (0.14)	-0.93 (-1.31, -0.55)
Nasal obstruction (0-10)	9.02 (0.83)	-2.54 (0.25)	8.92 (0.83)	-4.40 (0.25)	-1.86 (-2.53, -1.19)

CI: confidence interval; NPS: nasal polyp score at Week 52; SD: standard deviation; SE: standard error.
[a] Patients with nasal surgery were assigned worst possible score for the period after nasal surgery. Missing data were imputed based on available off-treatment data across treatment arms. Imputations were made stepwise by visit and conditioned on data from previous visits with the same covariates used in the analysis model.
[b] Least square means from analysis using mixed model repeated measures with covariates of treatment group, geographic region, baseline score, and log(e) baseline blood eosinophil count, visit, interaction terms for visit by baseline and visit by treatment.

Nasal Polypectomy

The key secondary endpoint was the time to first nasal surgery (nasal polypectomy) up to Week 52. The proportion of patients who had surgery was significantly reduced by 57% (hazard ratio [HR]: 0.43, 95% CI: 0.25, 0.76) in the group treated with Nucala 100 mg compared with the placebo group. By Week 52, 18 (9%) patients who received Nucala 100 mg had surgery compared with 46 (23%) patients in the placebo group.

Additional Chronic Rhinosinusitis with Nasal Polyps Symptoms Scores

For patients who received Nucala 100 mg, statistically significant improvement was observed in loss of smell compared to placebo and improvements were also observed in the individual VAS symptom scores compared with patients in the placebo group in the 4-weeks prior to the end of the 52-week treatment period (Table 4).

Table 4. Additional Visual Analog Scale Symptom Scores Assessed at Weeks 49-52

VAS Scores[a] (range)	Placebo n=201		Nucala 100 mg n=206		Mean Difference vs. Placebo (95% CI)
	Baseline Mean (SD)	Mean Change[b] (SE)	Baseline Mean (SD)	Mean Change[b] (SE)	
Loss of smell (0-10)	9.68 (0.60)	-1.46 (0.24)	9.63 (0.83)	-2.92 (0.24)	-1.46 (-2.11, -0.81)
Nasal discharge[c] (0-10)	8.78 (1.25)	-2.49 (0.26)	8.78 (1.07)	-4.38 (0.25)	-1.89 (-2.58, -1.20)
Mucus in the throat[c] (0-10)	8.58 (1.63)	-2.37 (0.26)	8.51 (1.61)	-4.07 (0.26)	-1.70 (-2.41, -0.99)
Facial pain[c] (0-10)	7.77 (2.72)	-2.04 (0.28)	7.76 (2.51)	-3.73 (0.27)	-1.69 (-2.43, -0.95)

VAS: visual analog scale; SD: standard deviation; SE: standard error; CI: confidence interval.
[a] Patients with nasal surgery were assigned the worst possible score for the period after nasal surgery. Missing data was imputed based on available off-treatment data across treatment arms. Imputations

were made stepwise by visit and conditioned on data from previous visits with the same covariates used in the analysis model.
[b] Least square means from an analysis using mixed model repeated measures with covariates of treatment group, geographic region, baseline score, and log(e) baseline blood eosinophil count visit, interaction terms for visit by baseline and visit by treatment.
[c] This endpoint was not prespecified in the analysis plan to adjust for multiplicity.

Corticosteroid Reduction
Treatment with Nucala 100 mg significantly reduced the need for systemic steroids for nasal polyps vs. placebo up to Week 52 (OR: 0.58, 95% CI: 0.36, 0.92). In patients who received Nucala 100 mg, 52 (25%) required ≥1 course of systemic steroids compared with 74 (37%) in the placebo group throughout the 52-week treatment period.

Results in Patients with Co-Morbid Asthma
In 289 (71%) patients with co-morbid asthma, pre-specified analyses showed improvements in the co-primary endpoints consistent with those seen in the overall population in the patients who received Nucala 100 mg compared with placebo. Additionally, based on a post-hoc analysis in these patients, there was a greater response from baseline at Week 52 in asthma control as measured by the Asthma Control Questionnaire (ACQ-5) for Nucala 100 mg compared with placebo (57% of the Nucala patients met the responder threshold reduction of ≥0.5, compared to 35% in the placebo group, with an OR of 2.42 [95% CI: 1.43, 4.11]).

Chronic Obstructive Pulmonary Disease (1)
The efficacy of Nucala as add-on maintenance treatment for adult patients with inadequately controlled chronic obstructive pulmonary disease (COPD) and an eosinophilic phenotype was evaluated in two randomized, double-blind, placebo-controlled, multicenter trials (MATINEE [NCT04133909] and METREX [NCT02105948]). The two trials enrolled a total of 1640 adults who were randomized to receive Nucala 100 mg or placebo administered subcutaneously every 4 weeks for a treatment duration of 52 to 104 weeks in MATINEE or 52 weeks in METREX. While 1640 adults were enrolled in the two clinical trials (MATINEE and METREX), the efficacy population consisted of 1266 adults.

Both trials enrolled patients with a diagnosis of COPD with moderate to very severe airflow limitation (post-bronchodilator FEV_1/FVC ratio <0.7 and post-bronchodilator FEV_1 of 20% to 80% predicted) and at least 2 moderate or 1 severe COPD exacerbation in the previous year despite receiving triple inhaled therapy.

In MATINEE, patients were required to have a minimum blood eosinophil count of 300 cell/mcL at screening. In METREX, there was no minimum blood eosinophil count requirement, but randomization was stratified by baseline blood eosinophil count: ≥150 cell/mcL at screening or ≥300 cell/mcL in the previous 12 months, or blood eosinophil count <150 cells/mcL at screening with no evidence of blood eosinophil count ≥300 cell/mcL in the previous 12 months. There was insufficient data from METREX to support the efficacy of Nucala in patients with COPD with blood eosinophil count <150 cells/mcL at screening with no evidence of blood eosinophil count

≥300 cell/mcL in the previous 12 months. Thus, the efficacy population (N=1266) included patients from MATINEE (n=804) and patients from METREX who had a blood eosinophil count ≥150 cell/mcL at screening or ≥300 cell/mcL in the previous 12 months (n=462).

Annualized Rate of Moderate or Severe Exacerbations in Adult Patients with Chronic Obstructive Pulmonary Disease
The primary endpoint for the MATINEE and METREX trials was the annualized rate of moderate or severe exacerbations during the 52 to 104-week and 52-week treatment periods, respectively. Moderate exacerbations are defined per protocol as clinically significant exacerbations that require treatment with oral/systemic corticosteroids and/or antibiotics. Severe exacerbations are defined per protocol as clinically significant exacerbations that require in-patient hospitalization (i.e., ≥24 hours) or result in death.

In both trials, Nucala demonstrated a statistically significant reduction in the annualized rate of moderate or severe exacerbations compared with placebo when added to triple inhaled therapy.

The time to first event analysis showed a statistically significant reduction in the risk of moderate or severe exacerbation for patients receiving Nucala compared to placebo (HR: 0.77; 95% CI: 0.64, 0.93) through 104 weeks in MATINEE.

Nucala reduced the annualized rate of COPD exacerbations requiring emergency department visits and/or hospitalization when compared with placebo (rate ratio [RR] of 0.65; 95% CI: 0.43, 0.96 [not statistically significant due to failure of an endpoint higher in the pre-defined testing hierarchy]) in MATINEE.

Health Related Quality of Life
In MATINEE and METREX, the St. George's Respiratory Questionnaire (SGRQ) total score responder rate (defined as the proportion of subjects with SGRQ improvement from baseline of at least 4 points) at Week 52 was evaluated. In MATINEE, the responder rate was 50% in the Nucala group compared with 46% in the placebo group (N=783, OR: 1.17; 95% CI: 0.87, 1.57). In the METREX efficacy population, the responder rate was 42% in the Nucala group compared to 40% in the placebo group (N=451, OR: 1.08; 95% CI: 0.74, 1.59).

<u>Eosinophilic Granulomatosis with Polyangiitis (EGPA) (1)</u>
A total of 136 adult patients with EGPA were evaluated in a randomized, placebo-controlled, multicenter, 52-week trial (NCT02020889). Patients received 300 mg of Nucala or placebo administered subcutaneously once every 4 weeks while continuing their stable OCS therapy. Starting at Week 4, OCS was tapered during the treatment period at the discretion of the investigator. Efficacy was assessed in this trial using co-endpoints of the total accrued duration of remission over the 52-week treatment period, defined as Birmingham Vasculitis Activity Score (BVAS) = 0 (no active vasculitis) plus prednisolone or prednisone dose less than or equal to 4 mg/day, and the proportion of patients in remission at both Week 36 and Week 48 of treatment. The BVAS is a clinician-completed tool to assess clinically active vasculitis that would likely require treatment, after exclusion of other causes.

Remission

Patients receiving 300 mg of Nucala achieved a significantly greater accrued time in remission compared with placebo. A significantly higher proportion of patients receiving 300 mg of Nucala achieved remission at both Week 36 and Week 48 compared with placebo (Table 5). In addition, significantly more patients receiving 300 mg of Nucala achieved remission within the first 24 weeks and remained in remission for the remainder of the 52-week trial treatment period compared with placebo (19% for 300 mg of Nucala versus 1% for placebo; OR: 19.7; 95% CI: 2.3, 167.9).

Table 5. Remission and Components of Remission in Eosinophilic Granulomatosis with Polyangiitis

	Remission (OCS ≤4 mg/day + BVAS = 0)		**OCS ≤4 mg/day**		**BVAS = 0**	
	Placebo n=68	**Nucala 300 mg n=68**	**Placebo n=68**	**Nucala 300 mg n=68**	**Placebo n=68**	**Nucala 300 mg n=68**
Accrued duration over 52 weeks, n (%)						
0	55 (81)	32 (47)	46 (68)	27 (40)	6 (9)	3 (4)
>0 to <12 weeks	8 (12)	8 (12)	12 (18)	5 (7)	15 (22)	13 (19)
12 to <24 weeks	3 (4)	9 (13)	6 (9)	12 (18)	11 (16)	5 (7)
24 to <36 weeks	0	10 (15)	2 (3)	10 (15)	17 (25)	2 (3)
≥36 weeks	2 (3)	9 (13)	2 (3)	14 (21)	19 (28)	45 (66)
Odds ratio (Nucala/ placebo)[a] (95% CI)		5.9 (2.7, 13.0)		5.1 (2.5, 10.4)		3.7 (1.8, 7.6)
Proportion of patients at both Weeks 36 and 48						
Patients, n (%)	2 (3)	22 (32)	7 (10)	28 (41)	23 (34)	34 (50)
Odds ratio (Nucala/ placebo)[a] (95% CI)		16.7 (3.6, 77.6)		6.6 (2.6, 17.1)		1.9 (0.9, 4.2)

OCS: oral corticosteroid; BVAS: Birmingham Vasculitis Activity Score; CI: confidence interval; mg: milligram.

[a] An odds ratio >1 favors Nucala.

Additionally, a statistically significant benefit for these endpoints was demonstrated using remission defined as BVAS = 0 plus prednisolone/prednisone ≤7.5 mg/day.

Relapse

The time to first relapse (defined as worsening related to vasculitis, asthma, or sino-nasal symptoms requiring an increase in dose of corticosteroids or immunosuppressive therapy or hospitalization) was significantly longer for patients receiving 300 mg of Nucala compared with placebo with an HR of 0.32 (95% CI: 0.21, 0.5). Additionally, patients receiving 300 mg of Nucala had a reduction in rate of relapse compared with patients receiving placebo (RR: 0.50; 95% CI: 0.36, 0.70 for 300 mg of Nucala compared with placebo). The incidence and number of relapse

types (vasculitis, asthma, sino-nasal) were numerically lower with Nucala compared with placebo.

Corticosteroid Reduction
Patients receiving 300 mg of Nucala had a significantly greater reduction in average daily OCS dose compared with patients receiving placebo during Weeks 48 to 52 (Table 6).

Table 6. Average Daily Oral Corticosteroid Dose during Weeks 48 to 52 in Eosinophilic Granulomatosis with Polyangiitis

	Number (%) of Patients	
	Placebo n=68	**Nucala 300 mg n=68**
0	2 (3)	12 (18)
>0 to ≤4.0 mg	3 (4)	18 (26)
>4.0 to ≤7.5 mg	18 (26)	10 (15)
>7.5 mg	45 (66)	28 (41)
Comparison: Nucala/placebo[a]		
Odds ratio[b]		0.20
95% CI		0.09, 0.41

CI: confidence interval; mg: milligram.
[a] Analyzed using a proportional odds model with covariates of treatment group, baseline oral corticosteroid daily dose, baseline Birmingham Vasculitis Activity Score, and region.
[b] An odds ratio <1 favors Nucala.

Asthma Control Questionnaire-6 (ACQ-6)
The ACQ-6, a 6-item questionnaire completed by the patient, was developed to measure the adequacy of asthma control and change in asthma control. The on-treatment ACQ-6 responder rate during Weeks 48 to 52 (defined as a decrease in score of 0.5 or more compared with baseline) was 22% for 300 mg of Nucala and 16% for placebo (OR: 1.56; 95% CI: 0.63, 3.88 for 300 mg of Nucala compared with placebo).

Hypereosinophilic Syndrome (HES) (1)
A total of 108 adult and adolescent patients aged 12 years and older with HES for at least 6 months were evaluated in a randomized, double-blind, placebo-controlled, multicenter, 32-week trial (NCT02836496). Patients with non-hematologic secondary HES (e.g., drug hypersensitivity, parasitic helminth infection, human immunodeficiency virus (HIV) infection, non-hematologic malignancy) or FIP1L1-PDGFRα kinase-positive HES were excluded from the trial. Patients received 300 mg of Nucala or placebo SC once every 4 weeks while continuing their stable HES therapy. Patients entering the trial had experienced at least 2 HES flares within the past 12 months and a blood eosinophil count of 1,000 cells/mcL or higher during screening. Historical HES flares for the trial entry criteria were defined as HES-related worsening of clinical symptoms or blood eosinophil counts requiring an escalation in therapy. Patients must have been on stable HES therapy for the 4 weeks prior to randomization. HES therapy could include chronic or episodic oral corticosteroids (OCS), immunosuppressive, or cytotoxic therapy.

The efficacy of Nucala in HES was established based upon the proportion of patients who experienced a HES flare during the 32-week treatment period. A HES flare was defined as worsening of clinical signs and symptoms of HES or increasing eosinophils (on at least 2 occasions), resulting in the need to increase OCS or increase/add cytotoxic or immunosuppressive HES therapy.

Flares

The trial compared the proportion of patients who experienced a HES flare or withdrew from the trial in the Nucala and placebo treatment groups (Table 7). Over the 32-week treatment period, the incidence of HES flare over the treatment period was 56% for the placebo group and 28% for the group treated with Nucala (50% reduction).

Table 7. Overview of Hypereosinophilic Syndrome Flares

	Number (%) of Patients	
	Placebo n=54	**Nucala 300 mg n=54**
Patients with ≥1 HES flare or who withdrew from trial	30 (56)	15 (28)
Patients with ≥1 HES flare	28 (52)	14 (26)
Patients with no HES flare who withdrew from trial	2 (4)	1 (2)
Comparison: Nucala/placebo[a]		
CMH *P* value		0.002
Odds ratio[b]		0.28
95% CI		(0.12, 0.64)

HES: Hypereosinophilic Syndrome; CMH: Cochran-Mantel-Haenszel; CI: confidence interval.

[a] Analysis compared the number of patients who experienced ≥1 HES flare and/or withdrew from the trial prematurely.

[b] An odds ratio <1 favors Nucala.

Time to First Flare

Difference was observed between Nucala and placebo arms in the time to first HES flare. The risk of first HES flare over the treatment period was 66% lower for patients treated with Nucala compared with placebo (HR: 0.34; 95% CI, 0.18, 0.67, *P* = 0.002).

Proportion of Patients Who Experienced Flares during Week 20 through Week 32

From Week 20 through Week 32, significantly fewer patients experienced a HES flare or withdrew from the trial when treated with 300 mg of Nucala compared with placebo (17% vs. 35%, respectively, *P* = 0.020; OR: 0.33; 95% CI: 0.13, 0.85).

Rate of Flares

Patients who received Nucala experienced significantly fewer HES flares during the 32-week treatment period compared with the placebo group (Table 8). Treatment with Nucala resulted in a statistically significant 66% reduction in the annualized rate of HES flares compared with placebo.

Table 8. Frequency of Flares

	Number (%) of Patients	
	Placebo n=54	**Nucala 300 mg n=54**
0	26 (48)	40 (74)
1	15 (28)	11 (20)
2	7 (13)	3 (6)
3	5 (9)	0
4	1 (2)	0
≥5	0	0
Comparison: Nucala/placebo		
Wilcoxon *P* value (unadjusted/adjusted)[a]		0.002/0.02
Rate/year	1.46	0.50
Rate ratio[b]		0.34
95% CI		(0.19, 0.63)

CI: confidence interval.

[a] Adjusted *P* values based on pre-specified hierarchy of endpoints.

[b] A rate ratio <1 favors Nucala.

Brief Fatigue Inventory

Brief Fatigue Inventory (BFI) Item 3 asks patients to record their worst level of weariness/ tiredness severity during the past 24 hours (scale: 0 = no fatigue to 10 = as bad as you can imagine). At baseline, median BFI Item 3 scores were similar between treatment groups (4.46 for Nucala 300 mg and 4.69 for placebo). At Week 32, BFI Item 3 scores improved with Nucala compared with placebo (*P* = 0.036). The median change from baseline score for BFI Item 3 at Week 32 was -0.66 in the group treated with Nucala and 0.32 in the placebo group.

Practice Guidelines and Position Statements

American Academy of Otolaryngology-Head and Neck Surgery (AAO)

In the 2025 Clinical Practice Guideline: Adult Sinusitis Update, for patients with suspected chronic rhinosinusitis with nasal polyps (CRwNP), the AAO states clinicians should objectively confirm sinonasal inflammation using nasal endoscopy or computed tomography (CT) imaging. (9) They state:

- Nasal Endoscopy
  - Direct visualization of polyps, making it ideal for confirming CRwNP.
  - Can obtain directed cultures when purulence is present.
  - Helps identify unilateral polyps that may signal alternative diagnoses (e.g., inverted papilloma).
- CT Imaging
  - Provides objective evaluation of sinus opacification, mucosal thickening, ostiomeatal obstruction, and extent of polyp burden.
  - Superior to endoscopy for seeing sinus cavities not accessible endoscopically and confirm inflammation when symptoms are present but endoscopy is normal.

- Superior for evaluating anatomy before surgery and ruling out neoplasm, bony erosion, or extra-sinus disease.

Coding

Procedure codes on Medical Policy documents are included **only** as a general reference tool for each policy. **They may not be all-inclusive.**

The presence or absence of procedure, service, supply, or device codes in a Medical Policy document has no relevance for determination of benefit coverage for members or reimbursement for providers. **Only the written coverage position in a Medical Policy should be used for such determinations.**

Benefit coverage determinations based on written Medical Policy coverage positions must include review of the member's benefit contract or Summary Plan Description (SPD) for defined coverage vs. non-coverage, benefit exclusions, and benefit limitations such as dollar or duration caps.

CPT Codes	96372
HCPCS Codes	J2182, J3490, J3590

*Current Procedural Terminology (CPT®) ©2025 American Medical Association: Chicago, IL.

References

Food and Drug Administration Label:

1. Prescribing Label: Nucala® (mepolizumab) for injection, for subcutaneous use. Aug 2025. Available at <https://www.accessdata.fda.gov/drugsatfda_docs/label/2025/761122s022lbl.pdf> (accessed March 11, 2026).

Other:

2. Nucala (mepolizumab) FDA Approval History. Available at <https://www.drugs.com> (accessed March 11, 2026).
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Centers for Medicare and Medicaid Services (CMS)

The information contained in this section is for informational purposes only. HCSC makes no representation as to the accuracy of this information. It is not to be used for claims adjudication for HCSC Plans.

The Centers for Medicare and Medicaid Services (CMS) does not have a national Medicare coverage position. Coverage may be subject to local carrier discretion.

A national coverage position for Medicare may have been developed since this medical policy document was written. See Medicare's National Coverage at <https://www.cms.hhs.gov>.

Policy History/Revision

Date	Description of Change
06/15/2026	Document updated. Coverage unchanged. Added reference 9; others updated.
01/01/2026	Document updated. The following changes were made to Coverage: 1) Modified conditional criteria under section on Eosinophilic Asthma; 2) Added conditional criteria for Eosinophilic Chronic Obstructive Pulmonary Disease; 3) Modified conditional criteria under section on Eosinophilic Granulomatosis with Polyangiitis; 4) Modified conditional criteria under section on Chronic Rhinosinusitis with Nasal Polyps; and 5) Modified experimental, investigational and/or unproven statement to "Mepolizumab (Nucala®) is considered experimental, investigational and/or unproven for all other non-FDA (Food and Drug Administration) approved indications." Added references 5 and 8; others updated and some removed.
04/15/2025	Document updated. The following change was made to Coverage: Added "The FDA has deemed the drug(s) or biological product(s) in this coverage policy to be appropriate for self-administration or administration by a caregiver (i.e., not a healthcare professional). Therefore, coverage of a formulation that cannot be self-administered is considered not medically necessary unless the patient has a physical or cognitive limitation that makes the utilization of a self-administered formulation unsafe or otherwise not feasible, as demonstrated by BOTH of the following: Inability to self-administer the medication, AND lack of caregiver or support system for assistance with administration of self-administered products." No new references added.
06/15/2024	Document updated with literature review. The following changes were made to Coverage: 1) Modified medical necessity criteria for Eosinophilic Asthma;

	2) Modified NOTE 1; and 3) Modified medical necessity criteria for Chronic Rhinosinusitis with Nasal Polyps. Reference 1 and 6 added.
05/01/2023	Reviewed. No changes.
12/01/2022	Document updated with literature review. The following change was made to Coverage: Added a medically necessary coverage statement for the treatment of chronic rhinosinusitis with nasal polyps, and removed it from the experimental, investigational and/or unproven coverage statement. Reference 5 added, others updated and some removed.
06/15/2021	Document updated with literature review. The following addition was made to Coverage criteria for eosinophilic asthma: "Will not be used in combination with another antiasthmatic monoclonal antibody agent (e.g., omalizumab [Xolair], benralizumab [Fasenra], reslizumab [Cinqair])". No new references added.
12/01/2020	Document updated with literature review. The following change was made to Coverage: Added a medically necessary coverage statement for the treatment of hypereosinophilic syndrome and NOTES 3 and 4. Added reference 2 and others updated. Title changed from Mepolizumab (Nucala).
03/15/2020	Document updated with literature review. The following change was made to Coverage: For the medically necessary statement of treatment of severe eosinophilic asthma the age was changed from 12 years of age or older to 6 years of age or older. Reference 3 was added.
07/15/2018	Document updated with literature review. The following change(s) were made: Added conditional coverage for the treatment of relapsing or refractory eosinophilic granulomatosis with polyangiitis (EGPA) (Churg-Strauss syndrome) and it removed from the experimental, investigational and/or unproven coverage statement. References 1 and 4 were added.
04/15/2017	Reviewed. No changes.
04/01/2016	New medical document. Mepolizumab may be considered medically necessary for the treatment of severe eosinophilic asthma when the following criteria are met: 10 Individual is 12 years of age or older; AND 2) Patient meets definition of severe asthma as defined by the following: 12 months of treatment with high-dose inhaled corticosteroid (ICS) in combination with long-acting beta2-agonist (LABA) or leukotriene receptor antagonist [LTRA]/theophylline for the previous year or systemic corticosteroids for 50% or more of the previous year to prevent asthma from becoming uncontrolled or remaining uncontrolled; AND NOTE: Patients who do not meet the criteria for uncontrolled asthma, but whose asthma worsens on tapering off corticosteroids, will also meet this definition of severe asthma. For definition of uncontrolled asthma see description section; 3) History of 2 or more exacerbations requiring systemic glucocorticoids while being treated with fluticasone propionate 880µg or more or its equivalent in the last year; AND 4) Eosinophil count of the following (in the absence of other potential causes of eosinophilia, including

	hypereosinophilic syndromes, neoplastic disease, and known or suspected parasitic infection): 150 cells/µL or more in peripheral blood at screening or 300 cells/µL or more during the previous year; NOTE: 1 microliter (ul) is equal to 1 cubic millimeter (mm3). Mepolizumab is considered experimental, investigational and/or unproven when not meeting criteria as outlined above and for all other indications, including but not limited to: Eosinophilic chronic obstructive pulmonary disease, Eosinophilic esophagitis, Eosinophilic granulomatosis with polyangiitis (EGPA) (Churg-Strauss syndrome), Nasal polyposis and Hypereosinophilic syndromes (other than severe eosinophilic asthma).