Mass General Brigham
Health Plan

Asthma and Allergy Injectables
Cinqair (reslizumab)
Fasenra (benralizumab)
Nucala (mepolizumab)
Xolair (omalizumab)
Tezspire (tezepelumab-ekko)
Effective 10/01/2025

Plan	☒ MassHealth ☐Commercial/Exchange	**Program Type**	☒ Prior Authorization ☐ Quantity Limit ☐ Step Therapy
Benefit	☐ Pharmacy Benefit ☒ Medical Benefit		
Specialty Limitations	N/A		
Contact Information	**Medical Benefit** **Pharmacy Benefit**	Phone: 833-895-2611 Phone: 800-711-4555	Fax: 888-656-6671 Fax: 844-403-1029
Exceptions	Fasenra, Nucala, Xolair, and Tezspire are also available on the pharmacy benefit. Please see the MassHealth Drug List for coverage and criteria. Additional agents from this class are available through the pharmacy benefit. Please see the MassHealth Drug List for coverage and criteria.		

Overview

Cinqair and **Fasenra** are interleukin-5 antagonist monoclonal antibodies indicated for:

- Add-on maintenance treatment of severe asthma for members with an eosinophilic phenotype.

Nucala is an interleukin-5 antagonist monoclonal antibody indicated for*:*

- Treatment of severe asthma with an eosinophilic phenotype
- Eosinophilic granulomatosis with polyangiitis
- Hypereosinophilic syndrome (HES)
- Chronis rhinosinusitis with nasal polyps (CRSwNP)

Xolair is an anti-IgE antibody indicated for:

- Treatment of moderate to severe persistent allergic asthma
- Chronic Idiopathic Urticaria (CIU)
- Treatment of nasal polyps in adults

Tezspire is a thymic stromal lymphopoietin (TSLP) blocker monoclonal antibody IgG2λ indicated for:

- Add-on maintenance treatment of adult and pediatric patients 12 years of age and older with severe asthma

Coverage Guidelines

Authorization may be reviewed on a case by case basis for members new to the plan who are currently receiving treatment and stable with the requested medication, excluding when the product is obtained as samples or via manufacturer's patient assistance program

OR

Authorization may be granted for members who meet all the following criteria and documentation has been provided:

Xolair (omalizumab)

Chronic Spontaneous Urticaria (CSU)

1. Diagnosis of chronic spontaneous urticaria
2. Prescriber is a specialist (i.e., allergist/immunologist or dermatologist) or consult notes from a specialist are provided
3. Member is ≥ 12 years of age
4. Inadequate response (defined as ≥14 days of therapy) or adverse reaction to at least **ONE** different histamine$_1$ antihistamines, or contraindication to **ALL** second generation histamine$_1$ antihistamines (See appendix for examples)
5. **ONE** of the following:
    a. Inadequate response (defined as ≥14 days of therapy) or adverse reaction to **ONE** of the following:
        i. Increased dose of a second generation histamine$_1$ antihistamine (up to four times the standard dose)
        ii. Second generation histamine$_1$ antihistamine in combination with a histamine$_2$ antihistamine
        iii. Second generation histamine$_1$ antihistamine in combination with a leukotriene receptor antagonist
        iv. Second generation histamine$_1$ antihistamine in combination with a first-generation histamine$_1$ antihistamine at bedtime
    b. **BOTH** of the following:
        i. Contraindication to **ALL** of the following:
            1. histamine$_2$ antihistamines
            2. first-generation histamine$_1$ antihistamines
            3. leukotriene receptor antagonists
        ii. Clinical rationale why the dose of a second generation histamine$_1$ antihistamine cannot be increased to up to four times the standard dose (See appendix for examples)
6. Appropriate dosing: 150 mg or 300 mg every 28 days. (See Appendix for dosing requests > 300 mg every 28 days)
7. If request is for the 150 mg or 300 mg syringe or auto-injection, medical necessity for the 150 mg syringe instead of the 150 mg vial (e.g., member will be self-administering)

IgE-Mediated Food Allergy

1. Diagnosis of IgE-Mediated Food Allergy
2. Prescriber is an allergist or immunologist or consultation notes from an allergist or immunologist are provided
3. Member is ≥ 1 year of age
4. Baseline serum IgE between 30 IU/mL to 1,850 IU/mL
5. Evidence of specific allergic sensitivity (i.e. positive skin test or blood test [radioallergosorbent test or RAST] for IgE)
6. Appropriate dosing (Dosing range is 75 to 600 mg subcutaneously every 14 to 28 days)
7. For the 150 mg or 300 mg syringe or auto-injection, medical necessity for the requested formulation instead of the vial (e.g., member will be self-administering)

Moderate to Severe Allergy Related Asthma

1. Diagnosis of moderate to severe allergy-related asthma
2. Member is ≥ 6 years of age
3. Member is symptomatic despite receiving **ONE** of the following:
    a. Combination inhaler (Advair, Breo, Dulera, fluticasone/salmeterol [Airduo], or Symbicort)
    b. Combination of an inhaled corticosteroid (Alvesco, ArmonAir, Arnuity, Asmanex, Flovent, Pulmicort or Qvar) **AND** a long-acting β-agonist inhaler (Serevent)
    c. Chronic oral corticosteroids (defined as ≥ 90 days of therapy within the last 120 days)
4. Baseline serum IgE between 30 IU/mL to 700 IU/mL ***see Appendix for higher IgE levels***
5. Evidence of specific allergic sensitivity (i.e. positive skin test or blood test [radioallergosorbent test or RAST] for IgE)
6. Prescriber is an asthma specialist (i.e., allergist, immunologist, pulmonologist) or consult notes from a specialist are provided
7. Appropriate dosing (Dosing range is 75 to 375 mg subcutaneously every two to four weeks [not exceeding 6 units/28 days for the 150 mg vial, 4 units/28 days for the 150 mg syringe, and 2 units/28 days for the 75 mg syringe]) †
8. If request is for the 150 mg syringe, medical necessity for the 150 mg syringe instead of the 150 mg vial (e.g., member will be self-administering)

Nasal Polyps

1. Diagnosis of nasal polyps
2. Member is ≥ 18 years of age
3. Prescriber is a specialist (i.e., allergist, immunologist, otolaryngologist, pulmonologist) or consult notes from a specialist are provided
4. **ONE** of the following:
    a. Inadequate response or adverse reaction to **ONE** or contraindication to **BOTH** of the following:
        i. oral corticosteroid
        ii. intranasal corticosteroid
    b. Inadequate response or adverse reaction to prior nasal surgery
5. Appropriate dosing: 75 to 600 mg every 14 to 28 days (based on weight and serum total IgE level)
6. If request is for Xolair 150 mg syringe, medical necessity for the 150 mg syringe instead of the 150 mg vial (e.g., member will be self-administering)
7. Documentation that agent will be used as adjunctive therapy

Systemic Mastocytosis (Off-Label)

1. Diagnosis of systemic mastocytosis
2. Prescriber is a specialist or consult notes from a specialist are provided (e.g., hematologist, oncologist, allergist, immunologist)
3. Inadequate response, adverse reaction, or contraindication to **ALL** of the following:
    a. Corticosteroids
    b. Histamine1 antihistamine
    c. Histamine2 antihistamine
4. Appropriate dosing (150 to 300 mg subcutaneously every 28 days)
5. For the 150 mg or 300 mg syringe or auto-injection, medical necessity for the requested formulation instead of the vial (e.g., member will be self-administering)

Nucala (mepolizumab)

Chronic Obstructive Pulmonary Disease (COPD)

1. Diagnosis of moderate to severe COPD

2. Prescriber is a specialist (i.e., pulmonologist, allergist, or immunologist) or consult notes from a specialist are provided
3. Appropriate dosing
4. **ONE** of the following:
    a. **BOTH** of the following:
        i. Inadequate response (defined as ≥ 90 days of therapy within a 120-day time period) or adverse reaction to **ONE** of the following or any combination of separate inhalers equivalent to **ONE** of the following
            1. Anoro (umeclidinium/vilanterol)
            2. Bevespi (glycopyrrolate/formoterol)
            3. Duaklir (aclidinium/formoterol)
            4. Stiolto (tiotropium/olodaterol)
        ii. Contraindication to the use of an inhaled corticosteroid (e.g., history of pneumonia)
    b. Inadequate response (defined as ≥ 90 days of therapy within a 120- day time period) or adverse reaction to **ONE** or any combination of separate inhalers equivalent to **ONE** of the following or contraindication to **BOTH** of the following:
        i. Breztri (budesonide/glycopyrrolate/formoterol)
        ii. Trelegy (fluticasone furoate/umeclidinium/vilanterol)
5. Evidence of an eosinophilic phenotype [i.e. peripheral blood eosinophil count ≥ 150 cells/µL
6. For members with an eosinophilic count ≥ 300 cells/µL an inadequate response, adverse reaction, or contraindication to Dupixent (dupilumab)
7. Requested agent will be used as adjunctive therapy with either dual or triple inhaled therapy

Eosinophilic granulomatosis with polyangiitis (EGPA)

1. Diagnosis of eosinophilic granulomatosis with polyangiitis
2. Member is ≥ 18 years of age
3. Prescriber is a specialist (i.e., allergist, cardiologist, hematologist, immunologist, pulmonologist, rheumatologist, etc.) or consult notes from a specialist are provided
4. Inadequate response (defined as ≥ 30 days of therapy) or adverse reaction to **ONE** systemic glucocorticoid, or contraindication to **ALL** systemic glucocorticoids
5. Appropriate dosing (300 mg subcutaneously every 28 days)

Hypereosinophilic syndrome (HES)

1. Diagnosis of hypereosinophilic syndrome
2. Documentation of diagnosis without an identifiable non-hematologic secondary cause
3. Prescriber is a specialist (i.e., allergist, cardiologist, GI, hematologist, immunologist, pulmonologist, etc) or consult notes from a specialist are provided
4. Member is ≥12 years of age
5. Inadequate response (defined as ≥ 30 days of therapy) or adverse reaction to **ONE** systemic glucocorticoid, or contraindication to **ALL** systemic glucocorticoids
6. Inadequate response (defined as ≥ 30 days of therapy) or adverse reaction to **ONE** or contraindication to **ALL** of the following:
    a. hydroxyurea
    b. methotrexate
    c. interferon alfa
7. Appropriate dosing (300 mg subcutaneously every 28 days)

Nasal Polyps

1. Diagnosis of chronic rhinosinusitis with nasal polyps
2. Member is ≥ 18 years of age
3. Prescriber is a specialist (i.e., allergist, immunologist, otolaryngologist, pulmonologist) or consult notes from a specialist are provided
4. **ONE** of the following:
    a. Inadequate response or adverse reaction to **ONE** or contraindication to **BOTH** of the following:
        i. oral corticosteroid
        ii. intranasal corticosteroid
    b. Inadequate response or adverse reaction to prior nasal surgery
5. Appropriate dosing: 100 mg every 4 weeks
6. Documentation that agent will be used as adjunctive therapy

Severe Eosinophilic Asthma

1. Diagnosis of severe eosinophilic asthma
2. Member is ≥ 6 years of age
3. Member is symptomatic despite receiving **ONE** of the following:
    a. Combination inhaler (Advair, Breo, Dulera, fluticasone/salmeterol [Airduo], or Symbicort)
    b. Combination of an inhaled corticosteroid (Alvesco, ArmonAir, Arnuity, Asmanex, Flovent, Pulmicort or Qvar) **AND** a long-acting β-agonist inhaler (Serevent)
    c. Chronic oral corticosteroids (defined as ≥ 90 days of therapy within the last 120 days)
4. Evidence of an eosinophilic phenotype (i.e. peripheral blood eosinophil count ≥ 150 cells/µL, elevated sputum eosinophils or FeNO)
5. Prescriber is an asthma specialist (i.e., allergist, immunologist, pulmonologist) or consult notes from a specialist are provided
6. Dosing is appropriate:
    a. For members ≥ 12 years of age, 100 mg subcutaneously every 28 days
    b. For members 6 to 11 years of age, 40 mg subcutaneously every 28 days

Cinqair (reslizumab)

Severe Eosinophilic Asthma

1. Diagnosis of severe eosinophilic asthma
2. Member is ≥ 18 years of age
3. Member is symptomatic despite receiving **ONE** of the following:
    a. Combination inhaler (Advair, Breo, Dulera, fluticasone/salmeterol [Airduo], or Symbicort)
    b. Combination of an inhaled corticosteroid (Alvesco, ArmonAir, Arnuity, Asmanex, Flovent, Pulmicort or Qvar) **AND** a long-acting β-agonist inhaler (Serevent)
    c. Chronic oral corticosteroids (defined as ≥ 90 days of therapy within the last 120 days)
4. Evidence of an eosinophilic phenotype (i.e. peripheral blood eosinophil count ≥ 400 cells/µL, elevated sputum eosinophils or FeNO)
5. Prescriber is an asthma specialist (i.e., allergist, immunologist, pulmonologist) or consult notes from a specialist are provided
6. Dosing is appropriate: 3 mg/kg intravenously every 4 weeks

Fasenra (benralizumab)

Eosinophilic granulomatosis with polyangiitis (EGPA)

1. Diagnosis of eosinophilic granulomatosis with polyangiitis
2. Member is ≥ 18 years of age

3. Prescriber is a specialist (i.e., allergist, cardiologist, hematologist, immunologist, pulmonologist, rheumatologist, etc.) or consult notes from a specialist are provided
4. Inadequate response (defined as ≥ 30 days of therapy) or adverse reaction to **ONE** systemic glucocorticoid, or contraindication to **ALL** systemic glucocorticoids
5. Appropriate dosing (30 mg subcutaneously every 28 days)

Severe Eosinophilic Asthma

1. Diagnosis of severe eosinophilic asthma
2. Member is ≥ 6 years of age
3. Member is symptomatic despite receiving **ONE** of the following:
    a. Combination inhaler (Advair, Breo, Dulera, fluticasone/salmeterol [Airduo], or Symbicort)
    b. Combination of an inhaled corticosteroid (Alvesco, ArmonAir, Arnuity, Asmanex, Flovent, Pulmicort or Qvar) **AND** a long-acting β-agonist inhaler (Serevent)
    c. Chronic oral corticosteroids (defined as ≥ 90 days of therapy within the last 120 days)
4. Evidence of an eosinophilic phenotype (i.e. peripheral blood eosinophil count ≥ 150 cells/µL, elevated sputum eosinophils or FeNO)
5. Prescriber is an asthma specialist (i.e., allergist, immunologist, pulmonologist) or consult notes from a specialist are provided
6. Dosing is appropriate:
    a. For members ≥ 12 years of age and members 6 to 11 years of age weighing ≥ 35 kg, 30 mg every 28 days for 3 doses, then 30 mg every 56 days
    b. For members 6 to 11 years of age weighing < 35 kg, 10 mg every 28 days for 3 doses, then 10 mg every 56 days

Severe Asthma

Tezspire (tezepelumab-ekko)

1. Diagnosis of severe asthma
2. Member is ≥ 12 years of age
3. Prescriber is an asthma specialist (i.e., allergist, immunologist, pulmonologist) or consult notes from a specialist are provided
4. Member is symptomatic despite receiving **ONE** of the following:
    a. Combination inhaler (Advair, Breo, Dulera, fluticasone/salmeterol [Airduo], or Symbicort)
    b. Combination of an inhaled corticosteroid (Alvesco, ArmonAir, Arnuity, Asmanex, Flovent, Pulmicort or Qvar) **AND** a long-acting β-agonist inhaler (Serevent)
    c. Chronic oral corticosteroids (defined as ≥ 90 days of therapy within the last 120 days)
5. Appropriate dosing

Continuation of Therapy

Resubmission by prescriber will infer a positive response to therapy.

Limitations

1. Initial approvals will be granted for the following:
    a. Chronic idiopathic urticaria: 4 months
    b. All other indications: 6 months
2. Reauthorizations will be granted for the following:
    a. Chronic idiopathic urticaria: 4 months
    b. All other diagnosis: 12 months

Appendix

Appendix A:

Examples of Traditional Therapies for CIU

H_1-Antihistamines (first generation):
Brompheniramine, carbinoxamine, chlorpheniramine, clemastine, cyproheptadine, diphenhydramine, hydroxyzine, promethazine, and doxepin

H_1-Antihistamines (second generation):
acrivastine/pseudoephedrine, cetirizine, desloratadine, fexofenadine, levocetirizine, loratadine

H_2-Antihistamines:
cimetidine, famotidine, nizatidine, ranitidine

Leukotriene Modifiers:
montelukast, zafirlukast, zileuton

Appendix B:

CIU: Omalizumab requests for > 300 mg every 4 Weeks

Requests for 450 mg every four weeks or 150 mg every two weeks can be approved for 3 months. If member has not achieved adequate response to this dosing, an allowance to 600 mg every four weeks or 300 mg every two weeks can be considered for a 3-month approval if provider submits request.

Recertification with either dosing will require documentation of positive response.

Appendix C:

Table 1. Moderate to Severe Allergy-Related Asthma for Patients ≥ 12 Years of Age: Xolair (omalizumab) administered every 2 to 4 weeks

Pre-treatment Serum IgE (IU/mL)	Body Weight (kg)			
	30-60	>60-70	>70-90	>90-150
≥ 30-100	150 mg	150 mg	150 mg	300 mg
> 100-200	300 mg	300 mg	300 mg	225 mg
> 200-300	300 mg	225 mg	225 mg	300 mg
> 300-400	225 mg	225 mg	300 mg	
> 400-500	300 mg	300 mg	375 mg	
> 500-600	300 mg	375 mg	DO NOT DOSE	
> 600-700	375 mg			
Every 2 weeks dosing				
Every 4 weeks dosing				

Table 2. Moderate to Severe Allergy-Related Asthma for Patients 6 to < 12 Years of Age: Xolair (omalizumab) administered every 2 to 4 weeks*

	Body Weight (kg)

Pre-treatment Serum IgE (IU/mL)	20-25	>25-30	>30-40	>40-50	>50-60	>60-70	> 70-80
≥ 30-100	75 mg	75 mg	75 mg	150 mg	150 mg	150 mg	150 mg
> 100-200	150 mg	150 mg	150 mg	300 mg	300 mg	300 mg	300 mg
> 200-300	150 mg	150 mg	225 mg	300 mg	300 mg	225 mg	225 mg
> 300-400	225 mg	225 mg	300 mg	225 mg	225 mg	225 mg	300 mg
> 400-500	225 mg	300 mg	225 mg	225 mg	300 mg	300 mg	375 mg
> 500-600	300 mg	300 mg	225 mg	300 mg	300 mg	375 mg	
> 600-700	300 mg	225 mg	225 mg	300 mg	375 mg		
>700-800	225 mg	225 mg	300 mg	375 mg			
>800-900	225 mg	225 mg	300 mg	375 mg			
>900-1000	225 mg	300 mg	375 mg				
>1000-1100	225 mg	300 mg	375 mg				
>1100-1200	300 mg	300 mg					
>1200-1300	300 mg	375 mg					
Every 2 weeks dosing							
Every 4 weeks dosing							
Do Not Dose							

*Additional dosing parameters are available for patients weighing >80 kg

Table 3. Nasal Polyps for Adults: Xolair (omalizumab) administered every 2 to 4 weeks[1]

Pre-treatment Serum IgE (IU/mL)	Body Weight (kg)						
	>30-40	>40-50	>50-60	>60-70	>70-80	>80-90	> 90-125*
30-100	75 mg	150 mg	150 mg	150 mg	150 mg	150 mg	300 mg
> 100-200	150 mg	300 mg	300 mg	300 mg	300 mg	300 mg	450 mg
> 200-300	225 mg	300 mg	300 mg	450 mg	450 mg	450 mg	600 mg
> 300-400	300 mg	450 mg	450 mg	450 mg	600 mg	600 mg	450 mg
> 400-500	450 mg	450 mg	600 mg	600 mg	375 mg	375 mg	525 mg
> 500-600	450 mg	600 mg	600 mg	375 mg	450 mg	450 mg	600 mg
> 600-700	450 mg	600 mg	375 mg	450mg	450 mg	525 mg	
>700-800	300 mg	375 mg	450 mg	450 mg	525 mg	600 mg	
>800-900	300 mg	375 mg	450 mg	525 mg	600 mg		
>900-1000	375 mg	450 mg	525 mg	600 mg			
>1000-1100	375 mg	450 mg	600mg				
>1100-1200	450 mg	525 mg	600 mg				
>1200-1300	450 mg	525 mg					
>1300-1500	525 mg	600 mg					
Every 2 weeks dosing							
Every 4 weeks dosing							
Do Not Dose							

*Refer to package insert for weight > 125 kg

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Review History

09/24/2018 – Updated

11/20/2019 – Updated to require only failure of separate ICS inhaler w/ LABA or combination product and removed requirement of DX based on diagnostic criteria

03/18/2020 – Reviewed and Updated P&T Mtg; age updated ≥ 6 years old for moderate to severe eosinophilic asthma (effective 6/1/20)
11/05/2020- Updated; Effective 1/1/21 Updated to be in compliance with the Masshealth partial unified formulary requirements
03/16/2022 – Updated and Reviewed for March P&T; Guideline updated based on FDA-expanded indication for use of Nucala (mepolizumab) in CRSwNP. Decision made to follow same criteria as Dupixent and Xolair for this indication. However, it was also decided to remove requirement of a trial with a leukotriene antagonist (LTRA) given the updated black box warnings regarding potential for serious neuropsychiatric events that have been reported with the use of montelukast. In addition, current guidelines mention that there is a low quality of available evidence comparing montelukast with nasal corticosteroids and do not routinely recommend use unless there is an allergic component to the disease. Similar decision was also made for Xolair CIU criteria to remove the requirement of LTRA trial. Based on expanded indication for use of dupilumab as add-on maintenance treatment of patients aged 6 to 11 years with moderate-to-severe asthma characterized by an eosinophilic phenotype or with oral-corticosteroid dependent asthma, criteria was updated to include new age range and new dupilumab formulation 100 mg/0.67 mL syringe was added to the internal guideline. Doxepin was added to appendix section as suitable option for H1 antihistamine trial for CIU and appendix section was updated for moderate to severe allergy-related asthma for omalizumab requests for members < 6 years of age based on consensus guideline recommendations for alternative agents. Two new appendices (Dupilumab requests for once weekly treatment and Dupilumab requests attempting to bypass systemic immunomodulatory agent) were included. The appendix "Omalizumab requests for members with high (>700 IU/mL) IgE levels or weight (<30 kg or >150 kg)" was removed.
05/18/2022 – Reviewed and Updated for May P&T. Updated references. Matched MH UPPL. Guideline updated following NDR for Tezspire (tezepelumab-ekko). Dupixent is preferred drug. Requirement for systemic immunomodulatory agent removed from Dupixent in AD criteria; criteria for Dupixent in nasal polyps changed to just one requirement to oral corticosteroid, intranasal corticosteroid, prior nasal surgery, or contraindication to both OCS and INS. Dupixent initial approvals changed from 6 months to 1 year duration. Reference table updated to include Preferred Drug footnote. Added the appendix "CIU: Omalizumab requests for > 300 mg every 4 weeks." The appendix "Moderate to Severe Atopic Dermatitis: Dupilumab requests attempting to bypass systemic immunomodulatory agent" was removed. Removed Foradil as a less costly alternative due to obsolete status. Effective 7/1/22.
11/16/2022 – Reviewed and updated for Nov P&T. Matched MH UPPL. Guideline update for expanded indications for Dupixent in children ≥ 6 months with moderate to severe atopic dermatitis as well as individuals ≥ 12 years of age with eosinophilic esophagitis. Effective 11/01/2022
3/15/23 – Reviewed and updated for Mar P&T. Admin update: Cinqair available through medical benefit. Effective 4/1/23.
05/10/23 – Reviewed and updated for P&T. Expanded indication for Dupixent in prurigo nodularis was added. Revision to Dupixent atopic dermatitis note section to allow for bypass of Eucrisa trial if disease is noted to be severe or if the affected area is noted to be too widespread. Included note that topical tacrolimus could be also bypassed if affected area noted to be too widespread. Added once-weekly dosing to Appendix. Effective 6/5/23.
07/12/23 – Reviewed and updated for P&T. Formatting changes made throughout policy. Brand preferred and mandatory generic language was added under Limitations. No clinical changes. Effective 7/31/23
05/15/25 – Reviewed and updated for P&T. Updated formatting and references. Dupixent removed from medical criteria as it is managed via pharmacy benefit only, available on MHDL. Effective 6/1/25
07/09/25 – Reviewed and updated for P&T. Aligning with MH criteria. Nucala for EGPA – removed trial/failure requirement of azathioprine and methotrexate. And added step-through with Fasenra. Added EGPA criteria for Fasenra and IgE-mediated food allergy for Xolair. Fasenra received expanded age indication to now include ≥ 6 years of age. Added Systemic Mastocytosis to Xolair. Effective 7/1/25

9/10/25 – Reviewed and updated for P&T. Xolair criteria for CIU was updated to CSU and step-through criteria was further elaborated. Nucala was updated to include COPD indication following an expanded indication update. Effective 10/1/25