Applicable Drugs: Exdensur (depemokumab)

Preferred: N/A

Non-preferred: N/A

Date of Origin: 6/1/2026

Date Last Reviewed / Revised: N/A

PRIOR AUTHORIZATION CRITERIA

(May be considered medically necessary when criteria I and VI are met)

I. Documented diagnosis of severe asthma with an eosinophilic phenotype and meets criteria A through C:
   A. Documented blood eosinophilia count ≥ 150 cells/mcL at baseline.
   B. Documentation that the patient has been on a minimum of a 6-month trial of a high-dose inhaled corticosteroid (ICS) used in combination with a long-acting inhaled beta-2 agonist (LABA).
   C. Documentation that the patient's asthma symptoms are poorly controlled despite therapy AND meets at least one of the following criteria 1 through 5:
      1. Poor symptom control (eg, Asthma Control Questionnaire [ACQ] score consistently greater than 1.5 or Asthma Control Test [ACT] score consistently less than 20)
      2. Two or more asthma exacerbations requiring systemic corticosteroids within the past 12 months.
      3. One or more asthma exacerbations requiring emergency treatment (ie, hospitalization, mechanical ventilation, emergency room visit) within the past 12 months.
      4. Worsening asthma when oral corticosteroids are tapered.
      5. Baseline forced expiratory volume in one second (FEV1) < 80% predicted.

II. Treatment must be prescribed by or in consultation with an allergist, immunologist, or pulmonologist.

III. Attestation that treatment will be administered by a healthcare provider.

IV. Minimum age requirement: 12 years old.

V. Request is for a medication with the appropriate FDA labeling, or its use is supported by current clinical practice guidelines.

VI. Refer to the plan document for the list of preferred products. If the requested agent is not listed as a preferred product, must have documented treatment failure or contraindication to the preferred product(s).

Exclusion Criteria

- Treatment of acute bronchospasm or status asthmaticus.
- Concurrent use with other anti-asthma monoclonal antibodies (ie, Cinqair (reslizumab), Dupixent (dupilumab), Fasenra (benralizumab), Nucala (mepolizumab), Tezspire (tezepelumab), Xolair (omalizumab)).

Other Criteria

- N/A

Quantity / Days Supply Restrictions

- Severe eosinophilic asthma: one 100 mg prefilled syringe every 6 months.

Approval Length

- **Authorization:** 6 months
- **Re-Authorization:** 12 months, with an updated letter of medical necessity or progress notes showing current medical necessity criteria are met and that the medication is effective.

Appendix

- N/A

References

1. Exdensur. Prescribing information. GSK LLC; 2025. Accessed June 1, 2026.
2. Global Initiative for Asthma. Global Strategy for Asthma Management and Prevention. 2026. Accessed June 1, 2026. https://ginasthma.org/2026-gina-strategy-report/
3. Global Initiative for Asthma. Adolescents and Adults with Difficult-To-Treat and Severe Asthma in Adolescent and Adult Patients: Diagnosis and Management V6.0. July 2025. Accessed June 1, 2026. https://ginasthma.org/severeasthma/
4. Butt NM, Lambert J, Ali S, et al. Guideline for the investigation and management of eosinophilia. *Br J Haematol*. 2017;176(4):553-572. doi:10.1111/bjh.14488

Disclaimer: Medication Policies are developed to help ensure safe, effective and appropriate use of selected medications. They offer a guide to coverage and are not intended to dictate to providers how to practice medicine. Refer to Plan for individual adoption of specific Medication Policies. Providers are expected to exercise their medical judgement in providing the most appropriate care for their patients.