

## Clinical Policy: Depemokimab-ulaa (Exdensur)

Reference Number: HIM.PA.179

Effective Date: 03.01.26

Last Review Date: 02.26

Line of Business: HIM

[Coding Implications](#)

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

### Description

Depemokimab-ulaa (Exdensur<sup>®</sup>) is an interleukin-5 antagonist monoclonal antibody (humanized immunoglobulin G [IgG]1 kappa).

### FDA Approved Indication(s)

Exdensur is indicated for add-on maintenance treatment of severe asthma characterized by an eosinophilic phenotype in adult and pediatric patients aged 12 years and older.

Limitation(s) of use: Exdensur is not indicated for the relief of acute bronchospasm or status asthmaticus.

### Policy/Criteria

*Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.*

It is the policy of health plans affiliated with Centene Corporation<sup>®</sup> that Exdensur is **medically necessary** when the following criteria are met:

#### I. Initial Approval Criteria

##### A. Severe Asthma (must meet all):

1. Diagnosis of asthma;
2. Member has an absolute blood eosinophil count  $\geq 150$  cells/mcL within the past 3 months;
3. Prescribed by or in consultation with an allergist, immunologist, or pulmonologist;
4. Age  $\geq 12$  years;
5. Member has experienced  $\geq 2$  exacerbations within the last 12 months, requiring one of the following (a or b) despite adherent use of controller therapy (i.e., medium- to high-dose inhaled corticosteroid [ICS] plus either a long acting beta-2 agonist [LABA] or leukotriene modifier [LTRA] if LABA contraindication/intolerance):
  - a. Oral/systemic corticosteroid treatment (or increase in dose if already on oral corticosteroid);
  - b. Urgent care/emergency room (ER) visit or hospital admission;
6. Failure of Dupixent<sup>®</sup> and Fasentra<sup>®</sup>, each used for  $\geq 4$  consecutive months at up to maximally indicated doses, unless clinically significant adverse effects are experienced or both are contraindicated;^

*\*Prior authorization may be required for Dupixent and Fasentra*

*^For Illinois HIM requests, the step therapy requirements above do not apply as of 1/1/2026 per IL HB 5395*

7. Exdensur is prescribed concurrently with an ICS plus either a LABA or LTRA;
8. Exdensur is not prescribed concurrently with Cinqair<sup>®</sup>, Fasenra, Nucala<sup>®</sup>, Dupixent, Xolair<sup>®</sup>, or Tezspire<sup>®</sup>;
9. Dose does not exceed 100 mg every 6 months.

**Approval duration: 12 months**

**B. Other diagnoses/indications (must meet 1 or 2):**

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
  - a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: HIM.PA.33 for health insurance marketplace; or
  - b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: HIM.PA.103 for health insurance marketplace; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: HIM.PA.154 for health insurance marketplace.

**II. Continued Therapy**

**A. Severe Asthma (must meet all):**

1. Member meets one of the following (a or b):
  - a. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
  - b. Member is currently receiving medication and is enrolled in a state and product with continuity of care regulations (*refer to state specific addendums for CC.PHARM.03A and CC.PHARM.03B*);
2. Demonstrated adherence to asthma controller therapy (an ICS plus either an LABA or LTRA) as evidenced by proportion of days covered (PDC) of 0.8 in the last 6 months (i.e., member has received asthma controller therapy for at least 5 of the last 6 months);
3. Member is responding positively to therapy (examples may include but are not limited to: reduction in exacerbations or corticosteroid dose, improvement in forced expiratory volume over one second since baseline, reduction in the use of rescue therapy);
4. Exdensur is not prescribed concurrently with Cinqair, Fasenra, Nucala, Dupixent, Xolair, or Tezspire;
5. If request is for a dose increase, new dose does not exceed 100 mg every 6 months.

**Approval duration: 12 months**

**B. Other diagnoses/indications (must meet 1 or 2):**

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):

- a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: HIM.PA.33 for health insurance marketplace; or
  - b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: HIM.PA.103 for health insurance marketplace; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: HIM.PA.154 for health insurance marketplace.

**III. Diagnoses/Indications for which coverage is NOT authorized:**

- A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies – HIM.PA.154 for health insurance marketplace or evidence of coverage documents;
- B. Acute bronchospasm or status asthmaticus.

**IV. Appendices/General Information**

*Appendix A: Abbreviation/Acronym Key*

GINA: Global Initiative for Asthma

ICS: inhaled corticosteroid

FDA: Food and Drug Administration

LABA: long-acting beta-agonist

LTRA: leukotriene modifier

PDC: proportion of days covered

*Appendix B: Therapeutic Alternatives*

*This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent and may require prior authorization.*

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
<b>ICS (medium – high dose)</b>		
Qvar <sup>®</sup> (beclomethasone)	> 200 mcg/day 40 mcg, 80 mcg per actuation 1-4 actuations BID	4 actuations BID
budesonide (Pulmicort <sup>®</sup> )	> 400 mcg/day 90 mcg, 180 mcg per actuation 2-4 actuations BID	2 actuations BID
Alvesco <sup>®</sup> (ciclesonide)	> 160 mcg/day 80 mcg, 160 mcg per actuation 1-2 actuations BID	2 actuations BID
fluticasone propionate (Flovent <sup>®</sup> )	> 250 mcg/day 44-250 mcg per actuation 2-4 actuations BID	2 actuations BID
Arnuity Ellipta <sup>®</sup> (fluticasone furoate)	200 mcg/day 100 mcg, 200 mcg per actuation 1 actuation QD	1 actuation QD
Asmanex <sup>®</sup> (mometasone)	> 200 mcg/day	2 inhalations BID

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
	HFA: 100 mcg, 200 mcg per actuation Twisthaler: 110 mcg, 220 mcg per actuation 1-2 actuations QD to BID	
<b>LABA</b>		
Serevent <sup>®</sup> (salmeterol)	50 mcg per dose 1 inhalation BID	1 inhalation BID
<b>Combination products (ICS + LABA)</b>		
Dulera <sup>®</sup> (mometasone/formoterol)	100/5 mcg, 200/5 mcg per actuation 2 actuations BID	4 actuations per day
Breo Ellipta <sup>®</sup> (fluticasone/vilanterol)	100/25 mcg, 200/25 mcg per actuation 1 actuation QD	1 actuation QD
fluticasone/salmeterol (Advair <sup>®</sup> )	Diskus: 100/50 mcg, 250/50 mcg, 500/50 mcg per actuation HFA: 45/21 mcg, 115/21 mcg, 230/21 mcg per actuation 1 actuation BID	1 actuation BID
fluticasone/salmeterol (Airduo RespiClick <sup>®</sup> )	55/13 mcg, 113/14 mcg, 232/14 mcg per actuation 1 actuation BID	1 actuation BID
budesonide/formoterol (Symbicort <sup>®</sup> )	80 mcg/4.5 mcg, 160 mcg/4.5 mcg per actuation 2 actuations BID	2 actuations BID
<b>LTRA</b>		
montelukast (Singulair <sup>®</sup> )	4 to 10 mg PO QD	10 mg per day
zafirlukast (Accolate <sup>®</sup> )	10 to 20 mg PO BID	40 mg per day
zileuton ER (Zyflo <sup>®</sup> CR)	1,200 mg PO BID	2,400 mg per day
Zyflo <sup>®</sup> (zileuton)	600 mg PO QID	2,400 mg per day
<b>Oral corticosteroids</b>		
dexamethasone (Decadron <sup>®</sup> )	0.75 to 9 mg/day PO in 2 to 4 divided doses	Varies
methylprednisolone (Medrol <sup>®</sup> )	40 to 80 mg PO in 1 to 2 divided doses	Varies
prednisolone (Millipred <sup>®</sup> , Orapred ODT <sup>®</sup> )	40 to 80 mg PO in 1 to 2 divided doses	Varies
prednisone (Deltasone <sup>®</sup> )	40 to 80 mg PO in 1 to 2 divided doses	Varies
<b>Other</b>		
Dupixent <sup>®</sup> (dupilumab)	<i>Adults and adolescents (12 years and older):</i> Initial dose of 400 mg SC followed by 200 mg SC every other week; or Initial dose of 600 mg SC followed by 300 mg SC every other week	See regimen

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
	For patients requiring concomitant oral corticosteroids or with co-morbid moderate-to-severe atopic dermatitis for which Dupixent is indicated, start with an initial dose of 600 mg SC followed by 300 mg SC every other week	
Fasenra <sup>®</sup> (benralizumab)	<u>Adult and adolescents (12 years and older):</u> 30 mg SC every 4 weeks for the first 3 doses, followed by once every 8 weeks thereafter	See regimen

Therapeutic alternatives are listed as Brand name<sup>®</sup> (generic) when the drug is available by brand name only and generic (Brand name<sup>®</sup>) when the drug is available by both brand and generic.

*Appendix C: Contraindications/Boxed Warnings*

None reported

*Appendix D: General Information*

- In the pivotal trials, patients were required to have 2 or more asthma exacerbations requiring treatment with systemic corticosteroids in the prior year while on background asthma therapy consisting of a medium- to high-dose ICS plus at least one additional asthma controller.
- Patients could potentially meet asthma criteria for both Xolair and Exdensus, though there is insufficient data to support the combination use of multiple asthma biologics. The combination has not been studied. Approximately 30% of patients in the Nucala MENSA study also were candidates for therapy with Xolair.
- Lab results for blood eosinophil counts can be converted into cells/mcL using the following unit conversion calculator: <https://www.gsksource.com/pharma/content/microsites/nucala-eos-calc/index.html>
- PDC is a measure of adherence. PDC is calculated as the sum of days covered in a time frame divided by the number of days in the time frame. To achieve a PDC of 0.8, a member must have received their asthma controller therapy for 144 days out of the last 180 days, or approximately 5 months of the last 6 months.

**V. Dosage and Administration**

Indication	Dosing Regimen	Maximum Dose
Severe asthma	100 mg SC every 6 months  Exdensus should be administered by a healthcare professional	100 mg/6 months

**VI. Product Availability**

- Single-dose prefilled pen: 100 mg/mL
- Single-dose prefilled syringe: 100 mg/mL

**VII. References**

1. Exdensus Prescribing Information. Philadelphia, PA: GlaxoSmithKline LLC; December 2025. Available at <http://www.exdensus.com>. Accessed January 5, 2026.
2. National Asthma Education and Prevention Program: Expert panel report III: Guidelines for the diagnosis and management of asthma. Bethesda, MD: National Heart, Lung, and Blood Institute, 2007. (NIH publication no. 08-4051). Available at <http://www.nhlbi.nih.gov/health-pro/guidelines/current/asthma-guidelines>.
3. Cloutier MM, Dixon AE, Krishnan JA, et al. Managing asthma in adolescents and adults 2020: asthma guideline update from the National Asthma Education and Prevention Program. JAMA. 2020; 324: 2301-2317.
4. Clinical Pharmacology [database online]. Philadelphia, PA: Elsevier. Updated periodically. Available at: <http://www.clinicalkey.com/pharmacology>. Accessed January 5, 2026.
5. Global Initiative for Asthma. Global strategy for asthma management and prevention (2025 update). Available at: [www.ginasthma.org](http://www.ginasthma.org). Accessed January 5, 2026.
6. Global Initiative for Asthma. Difficult-to-treat and severe asthma in adolescent and adult patients, v6.0, 2025. Available at: [www.ginasthma.org](http://www.ginasthma.org). Accessed January 7, 2026.
7. Jackson DJ, Wechsler ME, Jackson DJ, et al. Twice-yearly depemokimab in severe asthma with an eosinophilic phenotype. N Engl J Med 2024; 391: 2337-2349.

**Coding Implications**

Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

HCPCS Codes	Description
J2361	Injection, depemokimab-ulaa, 1 mg

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created	01.05.26	02.26
Added HCPCS code J2361 and removed codes J3590 and C9399.	06.02.26	

**Important Reminder**

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and

accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions, and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

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**Note:**

**For Medicaid members**, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

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