blue california
Promise Health Plan

depemokimab-ulaa (Exdensur)

Medical Benefit Drug Policy

Place of Service

Home Infusion
Infusion Center Administration
Office Administration
Outpatient Facility Infusion Administration

Drug Details

USP Category: ANTINEOPLASTICS
Mechanism of Action: Interleukin-5 (IL-5) antagonist
HCPCS:
C9399:Unclassified drugs or biologicals
J3490:Unclassified drugs
J3590:Unclassified biologics
How Supplied:

- 100 mg/mL solution in a single-dose, prefilled pen
- 100 mg/mL solution in a single-dose, prefilled syringe with needle guard

Condition(s) listed in policy *(see coverage criteria for details)*

- Severe Eosinophilic Asthma

Any condition not listed in this policy requires a review to confirm it is medically necessary. For conditions that have not been approved for intended use by the Food and Drug Administration (i.e., off-label use), the criteria outlined in the California Code of Regulations (CCR), Title 22, Section 51303 and 51313 must be met.

Special Instructions and Pertinent Information

Provider must submit documentation (such as office chart notes, lab results or other clinical information) to ensure the member has met all medical necessity requirements.

The member's specific benefit may impact drug coverage. Other utilization management processes, and/or legal restrictions may take precedence over the application of this clinical criteria.

Coverage Criteria

The following condition(s) require Prior Authorization/Preservice.

Severe Eosinophilic Asthma

Meets medical necessity if all the following are met:

Initial

1. Age is consistent with FDA approved indication (12 years of age and older)
2. Eosinophil blood count of at least 150 cells/µL

3. Asthma symptoms remain uncontrolled despite three months of treatment with a high-dose inhaled corticosteroid in combination with long-acting beta agonist (LABA) or leukotriene receptor antagonists (LTRA)
4. Meets ONE of the following within the past year (a, b, or c):
    1. One or more acute asthma-related ED visit(s)
    2. One or more acute inpatient visits where asthma was the principal diagnosis
    3. Use of chronic systemic steroids due to severe asthma OR two or more acute asthma exacerbations requiring oral systemic steroids
5. Will not be used in combination with another biologic medication for asthma (e.g., Cinqair, Dupixent, Fasenra, Nucala, Tezspire, or Xolair)
6. Dose does not exceed FDA approved maximum

Reauthorization

1. Not being used in combination with another biologic medication indicated for asthma treatment
2. Asthma symptoms have improved and/or controlled while on Exdensur
3. Dose does not exceed FDA approved maximum

Covered Doses:
100 mg given subcutaneously once every 6 months

Coverage Period:
one year

References

1. Exdensur (depemokimab-ulaa)) Prescribing Information. GlaxoSmithKline LLC, Philadelphia, PA: 12/2025.

Review History

Date of Last Annual Review: 1Q2026
Changes from previous policy version:

- New policy

Blue Shield of California Medication Policy to Determine Medical Necessity
Reviewed by P&T Committee