Louisiana Medicaid
Depemokimab-ulaa (Exdensur)

The *Louisiana Uniform Prescription Drug Prior Authorization Form* should be utilized to request clinical authorization for depemokimab-ulaa (Exdensur).

Additional Point-of-Sale edits may apply.

By submitting the authorization request, the prescriber attests to the conditions available HERE.

Approval Criteria for Initiation of Therapy

- The recipient is 12 years of age or older on the date of the request; **AND**
- The recipient has a diagnosis of severe asthma with an eosinophilic phenotype (severe allergic asthma); **AND**
- The prescriber **states on the** request that depemokimab-ulaa **IS** being used in combination with optimized pharmacotherapy for the treatment of asthma; **AND**
- The recipient has **ONE** of the following:
    - A blood eosinophil count of ≥150 cells/µL within the previous 6 weeks (prior to treatment with depemokimab-ulaa) [Date drawn and results are **stated on the request**]; **OR**
    - A blood eosinophil count of ≥300 cells/µL at any time within the previous 12 months (prior to treatment with depemokimab-ulaa) [Date drawn and results are **stated on the request**]; **AND**
- The recipient has been compliant for at least 3 consecutive months with optimized pharmacotherapy for the treatment of asthma, which is **stated on the request**; **AND**
- Even with compliant use of optimized pharmacotherapy for at least 3 consecutive months, the recipient's asthma continues to be uncontrolled as defined by **ONE** of the following which is **stated on the request**:
    - The recipient has had two or more asthma exacerbations which required treatment with systemic corticosteroids in the previous 12 months; **OR**
    - The recipient has had one or more asthma exacerbations requiring hospitalization or an ED visit in the previous 12 months; **OR**
    - The recipient has an FEV1 < 80% predicted; **OR**
    - The recipient has an FEV1/FVC < 0.80; **OR**
    - The recipient's asthma worsens upon tapering of oral corticosteroid therapy; **AND**
- Depemokimab-ulaa is **NOT** being used in combination with other monoclonal antibodies used to treat asthma; AND
- The dose is limited to 100mg once every 6 months; **AND**

- For a non-preferred agent, there is no preferred alternative that is the exact same chemical entity, formulation, strength, etc.; **AND**
- For a non-preferred agent, previous use of a preferred product - **ONE** of the following is required: (see Asthma / COPD – Immunomodulators on the PDL)
    - The recipient has had *treatment failure* with at least one preferred product; **OR**
    - The recipient has had an *intolerable side effect* to at least one preferred product; **OR**
    - The recipient has *documented contraindication(s)* to all of the preferred products that are appropriate for the condition being treated; **OR**
    - There is *no preferred product that is appropriate* to use for the condition being treated.

Approval Criteria for Continuation of Therapy

- The prescriber **states on the request** that the recipient is established on the medication with evidence of a positive response to therapy.

Duration of approval for initiation and continuation of therapy: 12 months

References

Asthma Management Guidelines: Focused Updates 2020. https://www.nhlbi.nih.gov/health-topics/asthma-management-guidelines-2020-updates

Exdensur (depemokimab-ulaa) [package insert]. Durham, NC: GlaxoSmithKline; December 2025. https://gskpro.com/content/dam/global/hcpportal/en_US/Prescribing_Information/Exdensur/pdf/EXDENSUR-PI-PIL.PDF

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