AETNA BETTER HEALTH®
Coverage Policy/Guideline

Name:	Exdensur	Page:	1 of 3
Effective Date:	3/20/2026	Last Review Date:	2/16/2026

Applies to:	☒ Illinois	☒ New Jersey	☒ Maryland
	☒ Florida Kids	☒ Pennsylvania Kids	☐ Virginia

Intent:

The intent of this policy/guideline is to provide information to the prescribing practitioner outlining the coverage criteria for Exdensur under the patient's prescription drug benefit.

Description:

FDA-Approved Indication

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

Limitations of Use

Not indicated for the relief of acute bronchospasm or status asthmaticus.
All other indications are considered experimental/investigational and not medically necessary.

Applicable Drug List:

Exdensur

Policy/Guideline:

The patient unable to take Dupixent, the preferred alternative for the given diagnosis, due to a trial and inadequate treatment response or intolerance, or a contraindication. Documentation is required for approval.

Documentation

Submission of the following information is necessary to initiate the prior authorization review:

Initial requests

- Chart notes or medical record documentation showing pre-treatment blood eosinophil count, or dependance on systemic corticosteroids, if applicable.
- Chart notes, medical record documentation, or claims history supporting previous medications tried including drug, dose, frequency, and duration.

Continuation requests

- Chart notes or medical record documentation supporting improvement in asthma control.

Prescriber Specialties

This medication must be prescribed by or in consultation with an allergist/immunologist or pulmonologist.

Coverage Criteria

Asthma

Authorization of 12 months may be granted for members 12 years of age or older who have previously received a biologic drug (e.g., Dupixent, Nucala) indicated for asthma in the past 12 months.

Authorization of 12 months may be granted for treatment of severe asthma when ALL of the following criteria are met:

- Member is 12 years of age or older.
- Member meets EITHER of the following criteria:
  - Member has a baseline blood eosinophil count of at least 150 cells per microliter.
  - Member is dependent on oral systemic corticosteroids.
- Member has uncontrolled asthma as demonstrated by experiencing at least ONE of the following within the past 12 months:
  - Two or more asthma exacerbations requiring oral or injectable corticosteroid treatment.
  - One or more asthma exacerbation(s) resulting in hospitalization or emergency medical care visit(s).
  - Poor symptom control (frequent symptoms or reliever use, activity limited by asthma, night waking due to asthma).
- Member has inadequate asthma control despite adherence to current treatment with BOTH of the following medications at maximal optimized doses:
  - High-dose inhaled corticosteroid (See Appendix).
  - Additional controller (i.e., long-acting beta2-agonist, long-acting muscarinic antagonist, leukotriene modifier, or sustained-release theophylline).
- Member will continue to use maintenance asthma treatments (e.g., inhaled corticosteroid and additional controller) in combination with the requested medication.

Continuation of Therapy

Asthma

Authorization of 12 months may be granted for treatment of severe asthma when ALL of the following criteria are met:

- Member is 12 years of age or older.
- Asthma control has improved on the requested medication as demonstrated by at least one of the following:
  - A reduction in the frequency and/or severity of symptoms and exacerbations
  - A reduction or discontinuation in the daily maintenance oral corticosteroid dose
- Member will continue to use maintenance asthma treatments (e.g., inhaled corticosteroid and additional controller) in combination with the requested medication.

Other

Member cannot use the requested medication concomitantly with any other biologic drug or targeted synthetic drug for the same indication.

Note: If the member is a current smoker or vaper, they should be counseled on the harmful effects of smoking and vaping on pulmonary conditions and available smoking and vaping cessation options.

Appendix

Table. Examples of High-dose Inhaled Corticosteroids (Alone or in Combination with LABA) for Adults and Adolescents (12 years and older)

Drug	Dosage Form	Total Daily Dose
Beclomethasone dipropionate	Pressurized metered-dose inhaler (pMDI), standard particle size hydrofluoroalkane propellant (HFA)	>1000 mcg
Beclomethasone dipropionate	Dry-powder inhaler (DPI) or pMDI, extra-fine particle size HFA	>400 mcg
Budesonide	DPI or pMDI, standard particle size HFA	>800 mcg
Ciclesonide	pMDI, extra-fine particle size HFA	>320 mcg
Fluticasone furoate	DPI	200 mcg
Fluticasone propionate	DPI or pMDI, standard particle size HFA	>500 mcg
Mometasone furoate	DPI or pMDI, standard particle size HFA	>400 mcg

Approval Duration and Quantity Restrictions:

Initial and Renewal Approval: 12 Months

Quantity Level Limit: 1 pen/syringe per 6 months

Reference Formulary for drug specific quantity level limits

References:

1. Exdensur [package insert]. Philadelphia, PA: GlaxoSmithKline LLC; December 2025.
2. 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.
3. Global Strategy for Asthma Management and Prevention. 2025. Available at: https://ginasthma.org/2025-gina-strategy-report/. Accessed December 18, 2025.
4. 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(22): 2301-2317.