Benralizumab (Fasenra®) Prefilled syringes	**Place of Service** **Office Administration** **Home Infusion Administration** **Infusion Center Administration** **Outpatient Facility Infusion Administration** **HCPCS**: **J0517** per 1 mg

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

- Severe eosinophilic asthma

AHFS therapeutic class: Interleukin antagonists

Mechanism of action: Interleukin-5 receptor antagonist monoclonal antibody

(1) Special Instructions and Pertinent Information

Fasenra prefilled syringes are managed under the Medical Benefit. Please submit clinical information for prior authorization review.

(2) Prior Authorization/Medical Review is required for the following condition(s)

All requests for Fasenra® (benralizumab) must be sent for clinical review and receive authorization prior to drug administration or claim payment.

Severe Eosinophilic Asthma

1. Prescribed by or in consultation with a pulmonologist, allergist, or immunologist, **AND**
1. Patient is at least 12 years of age, **AND**
2. One of the following:
    a. Eosinophil blood count of ≥ 300 cells/µL, or
    b. Eosinophil blood count of ≥150 cells/µL and currently on maximally tolerated oral corticosteroid,

    AND
3. Asthma symptoms remain uncontrolled despite 3 months of treatment with a high-dose inhaled corticosteroid in combination with long-acting beta agonist (LABA) or leukotriene receptor antagonists (LTRA), **AND**
4. Meets ONE of the following within the past year:
    a. One or more acute asthma-related ED visit(s), or
    b. One or more acute inpatient visits where asthma was the principal diagnosis, or
    c. Use of chronic systemic steroids due to severe asthma OR two or more acute asthma exacerbations requiring oral systemic steroids

    AND
5. Will not be used in combination with another biologic medication for asthma (e.g., Cinqair, Dupixent, Nucala, Xolair)

Covered Dose

Up to 30 mg SC every 4 weeks for first 3 doses, followed by once every 8 weeks

Coverage Period

Initial Authorization: 6 months
Reauthorization: Indefinite if the following criteria is met

1. Patient is not receiving this medication in combination with another biologic medication indicated for asthma treatment, AND
2. Provider attestation that asthma symptoms have improved and/or controlled while on Fasenra

ICD-10:
J45.20-J45.998

(3) The following condition(s) DO NOT require Prior Authorization/Preservice

All requests for Fasenra® (benralizumab) must be sent for clinical review and receive authorization prior to drug administration or claim payment.

(4) This Medication is NOT medically necessary for the following condition(s)

Coverage for a Non-FDA approved indication, requires that criteria outlined in Health and Safety Code § 1367.21, including objective evidence of efficacy and safety are met for the proposed indication.

Please refer to the Provider Manual and User Guide for more information.

(5) Additional Information

How Supplied:

- 30 mg/mL single-dose pre-filled syringe (Administered by healthcare provider)

(6) References

- AHFS®. Available by subscription at http://www.lexi.com
- DrugDex®. Available by subscription at http://www.micromedexsolutions.com/home/dispatch
- Fasenra® (benralizumab) [Prescribing Information]. Wilmington, DE: AstraZeneca; 2/2021.

- Global Initiative for Asthma. Global Strategy for Asthma Management and Prevention (2022 Update). Available from: www.ginasthma.org.

(7) Policy Update

Date of last review: 1Q2023

Date of next review: 1Q2024

Changes from previous policy version:

- No clinical change to policy following revision

BSC Drug Coverage Criteria to Determine Medical Necessity
Reviewed by P&T Committee