blue california
Promise Health Plan

benralizumab (Fasenra) prefilled syringe

Medical Benefit Drug Policy

Place of Service
Home Infusion Administration
Infusion Center Administration
Office Administration
Outpatient Facility Infusion Administration

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

- Eosinophilic Granulomatosis with Polyangiitis (EGPA) - formerly known as Churg-Strauss syndrome
- 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.

Eosinophilic Granulomatosis with Polyangiitis (EGPA) - formerly known as Churg-Strauss syndrome

Meets medical necessity if all the following are met:

1. Age is consistent with the FDA-approved indication (18 years and older)
2. Prescribed by or in consultation with an immunologist
3. Patient has relapsing or refractory disease despite treatment with oral corticosteroid (e.g., prednisone, prednisolone) or immunosuppressive therapy (e.g., azathioprine, methotrexate, mycophenolate mofetil)
4. ***Effective 2/1/2026 and after:*** Not being used in combination with other targeted immunomodulators for EGPA (e.g. Nucala)

Covered Doses:
Up to 30 mg given once every 4 weeks

Coverage Period:

Initial: 6 months
Reauthorization: Yearly if patient is responding to Fasenra

ICD-10:
M31.0

Severe Eosinophilic Asthma
Meets medical necessity if all the following are met:
Initial:
1. Age is consistent with FDA approved indication (6 years of age and older)
2. Eosinophil blood count of at least 150 cells/µL
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)
4. Meets one (1) of the following within the past year (a, b, or c):
   a. One or more acute asthma-related ED visit(s)
   b. One or more acute inpatient visits where asthma was the principal diagnosis,
   c. 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, Nucala, Xolair, or Tezspire)

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

Covered Doses:
Up to 30 mg given subcutaneously every 4 weeks for first 3 doses, followed by once every 8 weeks

Coverage Period:
Initial: 6 months
Reauthorization: Yearly

ICD-10:
J45.20-J45.998

References

1. AHFS. Available by subscription at http://www.lexi.com
2. DrugDex. Available by subscription at http://www.micromedexsolutions.com/home/dispatch

3. Fasenra (benralizumab) Prescribing Information. AstraZeneca, Wilmington, DE: August, 2025
4. Global Initiative for Asthma. (2025). Global strategy for asthma management and prevention. Updated July 2025. Available from https://ginasthma.org

Review History

Date of Last Annual Review: 4Q2025
Changes from previous policy version:

- Severe eosinophilic asthma: Removed specialist requirement (Rationale: Prescribing patterns consistent with expected specialists)
- Effective 2/1/2026 and after: For EGPA: will require use not in combination with other targeted immunomodulators. Rationale: ensure appropriate use

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