**MEDICATION POLICY:**
# Fasenra®

**Generic Name:** Benralizumab

**Therapeutic Class or Brand Name:** Fasenra

**Applicable Drugs (if Therapeutic Class):** N/A

**Preferred:** N/A

**Non-preferred:** N/A

**Date of Origin:** 3/6/2020

**Date Last Reviewed / Revised:** 8/15/2024

## PRIOR AUTHORIZATION CRITERIA

(May be considered medically necessary when criteria I and VI are met)

I. Documented diagnosis of severe asthma and must meet criteria A or B:
   A. Documented blood eosinophilia count ≥150 cells/mcL at baseline.
   B. Documentation that the patient has been on a minimum of a six-month trial of a high-dose inhaled corticosteroid (ICS) used in combination with a long-acting inhaled beta-2 agonist (LABA)

II. Documentation that the patient's asthma symptoms are poorly controlled despite therapy AND meets at least one of the following criteria a through e:
   A. Poor symptom control (eg, Asthma Control Questionnaire [ACQ] score consistently greater than 1.5 or Asthma Control Test [ACT] score consistently less than 20)
   B. Two or more asthma exacerbations requiring systemic corticosteroids within the past 12 months.
   C. One or more asthma exacerbations requiring emergency treatment (ie, hospitalization, mechanical ventilation, emergency room visit) within the past 12 months.
   D. Worsening asthma when oral corticosteroids are tapered.
   E. Baseline forced expiratory volume in one second (FEV1) less than 80% predicted.

III. Minimum age requirement: 6 years old.

IV. Treatment must be prescribed by or in consultation with an allergist, immunologist, or pulmonologist.

V. Request is for a medication with the appropriate FDA labeling, or its use is supported by current clinical practice guidelines.

VI. Refer to the plan document for the list of preferred products. If the requested agent is not listed as a preferred product, must have documented treatment failure or contraindication to the preferred product(s).

## EXCLUSION CRITERIA

- Treatment of other eosinophilic conditions.

- Treatment of acute bronchospasm or status asthmaticus.
- Concurrent use with other anti-asthma monoclonal antibodies (ie, Cinqair (reslizumab), Dupixent(dupilumab), Nucala (mepolizumab), Tezspire (tezepelumab), Xolair (omalizumab)).

## OTHER CRITERIA

- N/A

## QUANTITY / DAYS SUPPLY RESTRICTIONS

- One 30 mg pen or syringe every 28 days for the first 3 doses, then one 30 mg pen or syringe every 8 weeks.

## APPROVAL LENGTH

- **Authorization:** 6 months
- **Re-Authorization:** An updated letter of medical necessity or progress notes showing current medical necessity criteria are met and that the medication is effective.

## APPENDIX

- N/A

## REFERENCES

1. Fasenra. Prescribing information. AstraZeneca Pharmaceuticals; 2024. Accessed August 15, 2024. https://den8dhaj6zs0e.cloudfront.net/50fd68b9-106b-4550-b5d0-12b045f8b184/3647bed4-ce91-4fe7-9bc5-32dbee73f80a/3647bed4-ce91-4fe7-9bc5-32dbee73f80a_viewable_rendition__v.pdf
2. Chung KF, Wenzel SE, Brozek JL, et al. International ERS/ATS guidelines on definition, evaluation and treatment of severe asthma [published correction appears in *Eur Respir J*. 2014 Apr;43(4):1216. Dosage error in article text] [published correction appears in *Eur Respir J*. 2018 Jul 27;52(1):] [published correction appears in *Eur Respir J*. 2022 Jun 9;59(6):]. *Eur Respir J*. 2014;43(2):343-373. doi:10.1183/09031936.00202013
3. Global Initiative for Asthma. Difficult-to-treat & severe asthma in adolescent and adult patients: diagnosis and management V4.0. August 2023. Accessed October 15, 2023. https://ginasthma.org/severeasthma/