Montana Healthcare Programs
Physician Administered Drug Coverage Criteria

FASENRA® (benralizumab)

I. Medication Description

Fasenra® is an interleukin-5 alpha-directed cytolytic monoclonal antibody (IgG1, kappa) indicated for:

- Add-on maintenance treatment of patients with severe asthma aged 12 years and older, and with an eosinophilic phenotype.

II. Position Statement

Coverage is determined through a prior authorization process **that must include** supporting clinical documentation for each request.

III. Initial Coverage Criteria

Member must meet all of the following criteria:

- Member must be 12 years of age or older.
- Prescriber must be specialist or have an annual consult on file (Pulmonology/Allergy/Immunology).
- Diagnosis of severe uncontrolled asthma with an eosinophilic phenotype.
- Must provide baseline peripheral blood eosinophil count (attach lab report with eosinophil count).
    - Criteria: ≥300 cells/microliter (past 3-4 weeks)
- Member has a history of *severe* asthma attacks despite treatment with inhaled corticosteroid (ICS) in combination with long-acting beta$_2$-agonist (LABA) inhaler at optimized doses for 3 consecutive months.
- Provider attests that member will not use Fasenra® concomitantly with other biologics (e.g., Cinqair®, Dupixent®, Nucala®, Xolair®).

IV. Renewal Coverage Criteria

Member must meet all of the following criteria:

- Member has been adherent to Fasenra® and ICS/LABA therapy.
- Member has experienced a positive clinical response (reduction in frequency and/or severity of symptoms and exacerbations or medication dose reduction).
- Annual specialist consult provided if prescriber not a specialist**.**

V. Quantity Limitations

Max 30mg SQ every 4 weeks for first 3 doses, followed by once every 8 weeks thereafter.

VI. Coverage Duration

Initial approval duration: 6 months
Renewal approval duration: 1 year