Reference number(s)
2413-A

Specialty Guideline Management
Fasenra

Products Referenced by this Document

Drugs that are listed in the following table include both brand and generic and all dosage forms and strengths unless otherwise stated. Over-the-counter (OTC) products are not included unless otherwise stated.

Brand Name	Generic Name
Fasenra	benralizumab

Indications

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

FDA-approved Indications[1]

- Add-on maintenance treatment of adult and pediatric patients aged 6 years and older with severe asthma, and with an eosinophilic phenotype
- Treatment of adult patients with eosinophilic granulomatosis with polyangiitis (EGPA)

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.

Documentation

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

Asthma

Initial requests

- Chart notes or medical record documentation showing pretreatment 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.

EGPA

Initial requests

- Chart notes or medical record documentation showing pretreatment blood eosinophil count or percentage of blood eosinophil level (where applicable).
- Chart notes, medical record documentation, or claims history supporting previous medications tried including drug, dose, frequency and duration. If therapy is not advisable, documentation of clinical reason to avoid therapy.

Continuation requests

Chart notes or medical record documentation supporting beneficial response to treatment.

Prescriber Specialties

For the indication of asthma: This medication must be prescribed by or in consultation with an allergist/immunologist or pulmonologist.

Coverage Criteria

Asthma[1-5]

Authorization of 6 months may be granted for members 6 years of age or older who have previously received a biologic drug (e.g., Dupixent, Nucala) indicated for asthma in the past year.

Authorization of 6 months may be granted for treatment of severe asthma when all of the following criteria are met:

- Member is 6 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 systemic corticosteroids.
- Member has uncontrolled asthma as demonstrated by experiencing at least one of the following within the past year:
  - 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 current treatment with both of the following medications at optimized doses:
    - High-dose inhaled corticosteroid
    - 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 (i.e., inhaled corticosteroid and additional controller) in combination with the requested medication.

Eosinophilic granulomatosis with polyangiitis (EGPA)[1,6-8]

Authorization of 12 months may be granted for members 18 years of age or older who have previously received a biologic drug (e.g., Nucala) indicated for EGPA in the past year.

Authorization of 12 months may be granted for treatment of EGPA when all of the following criteria are met:

- Member is 18 years of age or older.
- Member has a history or the presence of a blood eosinophil count of more than 1000 cells per microliter or a blood eosinophil level of greater than 10%.
- Member is currently taking oral corticosteroids, unless contraindicated or not tolerated.
- Member has at least two of the following disease characteristics of EGPA:
    - Biopsy showing histopathological evidence of eosinophilic vasculitis, perivascular eosinophilic infiltration, or eosinophil-rich granulomatous inflammation
    - Neuropathy, mono or poly (motor deficit or nerve conduction abnormality)
    - Pulmonary infiltrates, non-fixed
    - Sino-nasal abnormality
    - Cardiomyopathy (established by echocardiography or magnetic resonance imaging)
    - Glomerulonephritis (hematuria, red cell casts, proteinuria)
    - Alveolar hemorrhage (by bronchoalveolar lavage)
    - Palpable purpura
    - Anti-neutrophil cytoplasmic anti-body (ANCA) positive (Myeloperoxidase or proteinase 3)
- Member has had at least one relapse (i.e., requiring increase in oral corticosteroid dose, initiation/increased dose of immunosuppressive therapy or hospitalization) within 2 years prior to starting treatment with the requested medication or has a refractory disease.

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 6 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 in the daily maintenance oral corticosteroid dose
- Member will continue to use maintenance asthma treatments (i.e., inhaled corticosteroid and additional controller) in combination with the requested medication.

Eosinophilic granulomatosis with polyangiitis (EGPA)

Authorization of 12 months may be granted for continuation of treatment of EGPA when all of the following criteria are met:

- Member is 18 years of age or older.
- Member has a beneficial response to treatment with the requested medication as demonstrated by any of the following:
    - A reduction in the frequency of relapses
    - A reduction or discontinuation of daily oral corticosteroid dose
    - No active vasculitis

Other

For all indications: 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.

References

1. Fasenra [package insert]. Wilmington, DE: AstraZeneca Pharmaceuticals LP; September 2024.
2. Nair P, Wenzel S, Rabe K, et al. Oral glucocorticoid-sparing effect of benralizumab in severe asthma. N Engl J Med. 2017;376:2448-2458.
3. Global Initiative for Asthma (GINA). Global Strategy for Asthma Management and Prevention. 2024 update. Available at: https://ginasthma.org/wp-content/uploads/2024/05/GINA-2024-Strategy-Report-24_05_22_WMS.pdf. Accessed March 1, 2025.
4. American Academy of Allergy, Asthma & Immunology (AAAAI) 2020 Virtual Annual Meeting. Available at: https://annualmeeting.aaaai.org/. Accessed March 8, 2025.
5. 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.
6. AstraZeneca. Efficacy and Safety of Benralizumab in EGPA Compared to Mepolizumab. (MANDARA) Available from https://clinicaltrials.gov/ct2/show/record/NCT04157348. NLM identifier: NCT04157348. Accessed March 16, 2025.
7. Groh M, Pagnoux C, Baldini C, et al. Eosinophilic granulomatosis with polyangiitis (Churg–Strauss) (EGPA) Consensus Task Force Recommendations for evaluation and management. Eur J Intern Med. 2015;26(7):545-553.
8. Chung SA, Langford CA, Maz M, et al. 2021 American College of Rheumatology/Vasculitis Foundation Guideline for the Management of Antineutrophil Cytoplasmic Antibody-Associated Vasculitis. Arthritis Rheumatol. 2021;73(8):1366-1383.