Clinical Policy: Benralizumab (Fasenra)
Reference Number: CP.PHAR.373
Effective Date: 01.16.18
Last Review Date: 02.19
Line of Business: Commercial, Medicaid, HIM-Medical Benefit

See Important Reminder at the end of this policy for important regulatory and legal information.

Description
Benralizumab (Fasenra™) is an interleukin (IL)-5 receptor alpha-directed cytolytic monoclonal antibody.

FDA Approved Indication(s)
Fasenra is indicated for the add-on maintenance treatment of patients with severe asthma aged 12 years and older, and with an eosinophilic phenotype.

Limitation(s) of use:
- Fasenra is not indicated for treatment of other eosinophilic conditions.
- Fasenra is not indicated for the relief of acute bronchospasm or status asthmaticus.

Policy/Criteria
Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation® that Fasenra is medically necessary when the following criteria are met:

I. Initial Approval Criteria
   A. Severe Asthma (must meet all):
      1. Diagnosis of asthma;
      2. Member has an absolute blood eosinophil count \( \geq \) 150 cells/mcL within the past 3 months;
      3. Prescribed by or in consultation with a pulmonologist, immunologist, or allergist;
      4. Age \( \geq \) 12 years;
      5. Member has experienced \( \geq \) 2 exacerbations within the last 12 months, requiring any of the following despite adherent use of controller therapy (i.e., medium- to high-dose inhaled corticosteroid (ICS) plus either a long-acting beta2 agonist (LABA) or leukotriene modifier (LTRA) if LABA contraindication/intolerance):
         a. Oral/systemic corticosteroid treatment (or increase in dose if already on oral corticosteroid);
         b. Urgent care visit or hospital admission;
         c. Intubation;
      6. Fasenra is prescribed concomitantly with an ICS plus either a LABA or LTRA;
      7. Dose does not exceed 30 mg every 4 weeks for the first 3 doses, then 30 mg every 8 weeks thereafter.
Approval duration: 6 months

B. Other diagnoses/indications
   1. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.CPA.09 for commercial and CP.PMN.53 for Medicaid and HIM-Medical Benefit.

II. Continued Therapy
   A. Severe Asthma (must meet all):
      1. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
      2. Demonstrated adherence to asthma controller therapy that includes an ICS plus either a LABA or LTRA;
      3. Member is responding positively to therapy;
      4. If request is for a dose increase, new dose does not exceed 30 mg every 8 weeks.
   Approval duration:
   Medicaid – 12 months
   Commercial – 6 months or member’s renewal period, whichever is longer

   B. Other diagnoses/indications (must meet 1 or 2):
      1. Currently receiving medication via Centene benefit and documentation supports positive response to therapy.
      Approval duration: Duration of request or 6 months (whichever is less); or
      2. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.CPA.09 for commercial, CP.PMN.53 for Medicaid and HIM-Medical Benefit.

III. Diagnoses/Indications for which coverage is NOT authorized:
   A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies – CP.CPA.09 for commercial, and CP.PMN.53 for Medicaid and HIM-Medical Benefit, or evidence of coverage documents;
   B. Acute bronchospasm or status asthmaticus.

IV. Appendices/General Information
   Appendix A: Abbreviation/Acronym Key
   FDA: Food and Drug Administration
   BEC: blood eosinophil count
   GINA: Global Initiative for Asthma
   ICS: inhaled corticosteroid
   IL: interleukin
   LABA: long-acting beta$_2$ agonist
   LTRA: leukotriene modifier
### Appendix B: Therapeutic Alternatives

This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent and may require prior authorization.

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Dosing Regimen</th>
<th>Dose Limit/Maximum Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ICS (medium – high dose)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Qvar® (beclomethasone)</td>
<td>&gt; 200 mcg/day 40 mcg, 80 mcg per actuation 1-4 actuations BID</td>
<td>4 actuations BID</td>
</tr>
<tr>
<td>budesonide (Pulmicort®)</td>
<td>&gt; 400 mcg/day 90 mcg, 180 mcg per actuation 2-4 actuations BID</td>
<td>2 actuations BID</td>
</tr>
<tr>
<td>Alvesco® (ciclesonide)</td>
<td>&gt; 160 mcg/day 80 mcg, 160 mcg per actuation 1-2 actuations BID</td>
<td>2 actuations BID</td>
</tr>
<tr>
<td>Aerospan® (flunisolide)</td>
<td>&gt; 320 mcg/day 80 mcg per actuation 2-4 actuations BID</td>
<td>2 actuations BID</td>
</tr>
<tr>
<td>Flovent® (fluticasone propionate)</td>
<td>&gt; 250 mcg/day 44-250 mcg per actuation 2-4 actuations BID</td>
<td>2 actuations BID</td>
</tr>
<tr>
<td>Arnuity Ellipta® (fluticasone furoate)</td>
<td>200 mcg/day 100 mcg, 200 mcg per actuation 1 actuation QD</td>
<td>1 actuation QD</td>
</tr>
<tr>
<td>Asmanex® (mometasone)</td>
<td>&gt;220 mcg/day HFA: 100 mcg, 200 mcg per actuation Twisthaler: 110 mcg, 220 mcg per actuation 1-2 actuations QD to BID</td>
<td>2 inhalations BID</td>
</tr>
<tr>
<td><strong>LABA</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Serevent® (salmeterol)</td>
<td>50 mcg per dose 1 inhalation BID</td>
<td>1 inhalation BID</td>
</tr>
<tr>
<td><strong>Combination products (ICS + LABA)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dulera® (mometasone/formoterol)</td>
<td>100/5 mcg, 200/5 mcg per actuation 2 actuations BID</td>
<td>4 actuations per day</td>
</tr>
<tr>
<td>Breo Ellipta® (fluticasone/vilanterol)</td>
<td>100/25 mcg, 200/25 mcg per actuation 1 actuation QD</td>
<td>1 actuation QD</td>
</tr>
<tr>
<td>Advair® (fluticasone/salmeterol)</td>
<td>Diskus: 100/50 mcg, 250/50 mcg, 500/50 mcg per actuation HFA: 45/21 mcg, 115/21 mcg, 230/21 mcg per actuation 1 actuation BID</td>
<td>1 actuation BID</td>
</tr>
<tr>
<td>fluticasone/salmeterol (Airduo RespiClick®)</td>
<td>55/13 mcg, 113/14 mcg, 232/14 mcg per actuation 1 actuation BID</td>
<td>1 actuation BID</td>
</tr>
<tr>
<td>Drug Name</td>
<td>Dosing Regimen</td>
<td>Dose Limit/ Maximum Dose</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>-----------------------------------------------------</td>
<td>--------------------------</td>
</tr>
<tr>
<td>Symbicort® (budesonide/formoterol)</td>
<td>80 mcg/4.5 mcg, 160 mcg/4.5 mcg per actuation</td>
<td>2 actuations BID</td>
</tr>
<tr>
<td>LTRA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>montelukast (Singular®)</td>
<td>4 to 10 mg PO QD</td>
<td>10 mg per day</td>
</tr>
<tr>
<td>zafirlukast (Accolate®)</td>
<td>10 to 20 mg PO BID</td>
<td>40 mg per day</td>
</tr>
<tr>
<td>zileuton ER (Zyflo® CR)</td>
<td>1200 mg PO BID</td>
<td>2,400 mg per day</td>
</tr>
<tr>
<td>Zyflo® (zileuton)</td>
<td>600 mg PO QID</td>
<td>2,400 mg per day</td>
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<tr>
<td>Oral corticosteroids</td>
<td></td>
<td></td>
</tr>
<tr>
<td>dexamethasone (Decadron®)</td>
<td>0.75 to 9 mg/day PO in 2 to 4 divided doses</td>
<td>Varies</td>
</tr>
<tr>
<td>methylprednisolone (Medrol®)</td>
<td>40 to 80 mg PO in 1 to 2 divided doses</td>
<td>Varies</td>
</tr>
<tr>
<td>prednisolone (Millipred®, Orapred ODT®)</td>
<td>40 to 80 mg PO in 1 to 2 divided doses</td>
<td>Varies</td>
</tr>
<tr>
<td>prednisone (Deltasone®)</td>
<td>40 to 80 mg PO in 1 to 2 divided doses</td>
<td>Varies</td>
</tr>
</tbody>
</table>

Therapeutic alternatives are listed as Brand name® (generic) when the drug is available by brand name only and generic (Brand name®) when the drug is available by both brand and generic.

Appendix C: Contraindications/Boxed Warnings
- Contraindication(s): hypersensitivity
- Boxed warning(s): none reported

Appendix D: General Information
- The pivotal trials defined severe asthma as 2 or more exacerbations of asthma despite regular use of high-dose ICS plus an additional controller (e.g., LABA or LTRA) with or without oral corticosteroids. Although the CALIMA trial included patients receiving medium-dose ICS, Fasenra was not shown to have an effect on annual exacerbation rate, pre-bronchodilator forced expiratory volume in 1 second, or total asthma symptom score in those patients.
- Clinically significant exacerbation was defined as a worsening of asthma (any new or increased symptoms or signs that were concerning) that led to one of the following: (1) use of systemic corticosteroids, (2) emergency department or visit to urgent care center, or (3) inpatient hospital stay.
- Baseline blood eosinophil count (BEC) is a predictor of response to therapy. Although the SIROCCO and CALIMA trials were powered for efficacy analysis in patients with baseline BEC ≥ 300 cells/µL, a pooled analysis which stratified patients by baseline BEC (≥ 0 cells/µL, ≥ 150 cells/µL, ≥ 300 cells/µL, and ≥ 450 cells/µL) found Fasenra to have a statistically significant positive treatment effect on those with baseline BEC ≥ 150 cells/µL. In addition, the ZONDA trial found Fasenra to significantly reduce oral corticosteroid dose in patients with baseline BEC ≥ 150 cells/µL.
• Positive response to therapy for asthma may include reduction in exacerbations or corticosteroid dose, improvement in forced expiratory volume over one second since baseline, or reduction in the use of rescue therapy.
• Lab results for blood eosinophil counts can be converted into cells/mcL using the following unit conversion calculator: https://www.fasenrahcp.com/m/fasenra-eosinophil-calculator.html

V. Dosage and Administration

<table>
<thead>
<tr>
<th>Indication</th>
<th>Dosing Regimen</th>
<th>Maximum Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Severe asthma</td>
<td>30 mg SC every 4 weeks for the first 3 doses, followed by once every 8 weeks thereafter</td>
<td>See regimen</td>
</tr>
</tbody>
</table>

VI. Product Availability

Single-dose prefilled syringe with solution for injection: 30 mg/mL

VII. References


Coding Implications

Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

<table>
<thead>
<tr>
<th>HCPCS Codes</th>
<th>Description</th>
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<tbody>
<tr>
<td>C9466</td>
<td>Injection, benralizumab, 1 mg</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reviews, Revisions, and Approvals</th>
<th>Date</th>
<th>P&amp;T Approval Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy created</td>
<td>01.16.18</td>
<td>05.18</td>
</tr>
<tr>
<td>1Q 2019 annual review: modified ICS requirement to include medium dose ICS per GINA 2018 recommendations; added option for immunologist prescribing; link to blood eosinophil unit conversion calculator added to Appendix D; references reviewed and updated.</td>
<td>10.11.18</td>
<td>02.19</td>
</tr>
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</table>
**CLINICAL POLICY**  
Benralizumab

<table>
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<tbody>
<tr>
<td>Added HIM-Medical Benefit line of business.</td>
<td>05.22.19</td>
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</tbody>
</table>

**Important Reminder**

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

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Note:
For Medicaid members, when state Medicaid coverage provisions conflict with the coverage
provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please
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