Clinical Policy: Benralizumab (Fasenra)

Reference Number: HIM.PA.SP70
Effective Date: 12.01.24
Last Review Date: 12.25
Line of Business: HIM*

Coding Implications
Revision Log

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

Description

Benralizumab (Fasenra®) is an interleukin-5 receptor alpha-directed cytolytic monoclonal antibody (IgG1 kappa).

** **NY CHIP Plans should** be approved using these criteria*

FDA Approved Indication(s)

Fasenra is indicated for the:

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

Limitation(s) of use: 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 ≥ 150 cells/mcL within the past 3 months;
3. Prescribed by or in consultation with a pulmonologist, immunologist, or allergist;
4. Age ≥ 6 years;
5. Member has experienced ≥ 1 exacerbation within the last 12 months, requiring one of the following (a or b), despite adherent use of controller therapy (i.e., medium- to high-dose inhaled corticosteroid [ICS] plus a long-acting beta$_2$ agonist [LABA] or ICS plus one additional asthma controller medication):
   a. Oral/systemic corticosteroid treatment (or increase in dose if already on oral corticosteroid);
   b. Urgent care/emergency room (ER) visit or hospital admission;

6. Fasenra is prescribed concurrently with an ICS plus either a LABA or one additional asthma controller medication;
7. Fasenra is not prescribed concurrently with Cinqair®, Nucala®, Dupixent®, Xolair®, or Tezspire®;
8. Dose does not exceed (a or b):
   a. Age 6 to 11 years and weight < 35 kg: 10 mg every 4 weeks for the first 3 doses, then 10 mg every 8 weeks thereafter;
   b. Age ≥ 6 years and weight ≥ 35 kg: 30 mg every 4 weeks for the first 3 doses, then 30 mg every 8 weeks thereafter.

Approval duration: 12 months

B. Eosinophilic Granulomatosis with Polyangiitis (formerly Churg-Strauss) (must meet all)**:**

1. Diagnosis of EGPA (formerly Churg-Strauss) with both of the following (a and b):
   a. Active, non-severe disease;*
      **Non-severe disease is defined as vasculitis without life- or organ-threatening manifestations. Examples of symptoms in patients with non-severe disease include rhinosinusitis, asthma, mild systemic symptoms, uncomplicated cutaneous disease, and mild inflammatory arthritis.*
   b. Eosinophilia as evidenced by one of the following (i, ii, or iii):
      i. Absolute eosinophil count > 1 x 10^9/L (> 1,000 cells/mcL) within the past 3 months;
      ii. Eosinophils > 10% of leukocytes within the past 3 months;
      iii. If member has received prior monoclonal antibody therapy that can alter blood eosinophil levels (e.g., Fasenra): Blood eosinophil level ≥ 150 cells/mcL prior to treatment;
2. Prescribed by or in consultation with a pulmonologist, rheumatologist, immunologist, or nephrologist;
3. Age ≥ 18 years;
4. Member is currently receiving standard therapy for EGPA (i.e., glucocorticoid [*see Appendix B*] with or without immunosuppressive therapy), unless contraindicated or clinically significant adverse events are experienced;
5. Fasenra is not prescribed concurrently with Cinqair, Nucala, Dupixent, Xolair, or Tezspire;
6. Dose does not exceed 30 mg every 4 weeks.

Approval duration: 12 months

C. Other diagnoses/indications (must meet 1 or 2)**:**

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: HIM.PA.33 for health insurance marketplace; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: HIM.PA.103 for health insurance marketplace; or

2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: HIM.PA.154 for health insurance marketplace.

II. Continued Therapy

A. Severe Asthma (must meet all)**:**

1. Member meets one of the following (a or b):
   a. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
   b. Member is currently receiving medication and is enrolled in a state and product with continuity of care regulations (*refer to state specific addendums for CC.PHARM.03A and CC.PHARM.03B)*;
2. Demonstrated adherence to asthma controller therapy (an ICS plus either a LABA or one additional asthma controller medication) as evidenced by proportion of days covered (PDC) of 0.8 in the last 6 months (i.e., member has received asthma controller therapy for at least 5 of the last 6 months);
3. Member is responding positively to therapy (examples may include but are not limited to: reduction in exacerbations or corticosteroid dose, improvement in forced expiratory volume over one second since baseline, reduction in the use of rescue therapy);
4. Fasenra is not prescribed concurrently with Cinqair, Nucala, Dupixent, Xolair, or Tezspire;
5. If request is for a dose increase, new dose does not exceed (a or b):
   a. Age 6 to 11 years and weight < 35 kg: 10 mg every 4 weeks for the first 3 doses, then 10 mg every 8 weeks thereafter;
   b. Age ≥ 6 years and weight ≥ 35 kg: 30 mg every 4 weeks for the first 3 doses, then 30 mg every 8 weeks thereafter.

Approval duration: 12 months

B. Eosinophilic Granulomatosis with Polyangiitis (formerly Churg-Strauss) (must meet all)**:**

1. Member meets one of the following (a or b):
   a. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
   b. Member is currently receiving medication and is enrolled in a state and product with continuity of care regulations (*refer to state specific addendums for CC.PHARM.03A and CC.PHARM.03B);*
2. Member is responding positively to therapy (examples may include but are not limited to: reduction of relapses or reduction in glucocorticoid dose);
3. Fasenra is not prescribed concurrently with Cinqair, Nucala, Dupixent, Xolair, or Tezspire;
4. If request is for a dose increase, new dose does not exceed 30 mg every 4 weeks.

Approval duration: 12 months

C. Other diagnoses/indications (must meet 1 or 2)**:**
1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: HIM.PA.33 for health insurance marketplace; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: HIM.PA.103 for health insurance marketplace; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: HIM.PA.154 for health insurance marketplace.

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 – HIM.PA.154 for health insurance marketplace or evidence of coverage documents;

B. Acute bronchospasm or status asthmaticus.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

BEC: blood eosinophil count
EGPA: eosinophilic granulomatosis with polyangiitis
ER: emergency room
FDA: Food and Drug Administration
GINA: Global Initiative for Asthma
ICS: inhaled corticosteroid
LABA: long-acting beta$_2$ agonist
LTRA: leukotriene modifier
PDC: proportion of days covered

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.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Asthma - ICS (medium – high dose)		
Qvar® (beclomethasone)	> 200 mcg/day 40 mcg, 80 mcg per actuation 1-4 actuations BID	4 actuations BID
budesonide (Pulmicort®)	> 400 mcg/day 90 mcg, 180 mcg per actuation 2-4 actuations BID	2 actuations BID
Alvesco® (ciclesonide)	> 160 mcg/day 80 mcg, 160 mcg per actuation 1-2 actuations BID	2 actuations BID

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
fluticasone propionate (Flovent®)	> 250 mcg/day 44-250 mcg per actuation 2-4 actuations BID	2 actuations BID
Arnuity Ellipta® (fluticasone furoate)	200 mcg/day 100 mcg, 200 mcg per actuation 1 actuation QD	1 actuation QD
Asmanex® (mometasone)	> 200 mcg/day HFA: 100 mcg, 200 mcg per actuation Twisthaler: 110 mcg, 220 mcg per actuation 1-2 actuations QD to BID	2 inhalations BID
Asthma - LABA		
Serevent® (salmeterol)	50 mcg per dose 1 inhalation BID	1 inhalation BID
Asthma - Combination products (ICS + LABA)		
Dulera® (mometasone/ formoterol)	100/5 mcg, 200/5 mcg per actuation 2 actuations BID	4 actuations per day
Breo Ellipta® (fluticasone/vilanterol)	100/25 mcg, 200/25 mcg per actuation 1 actuation QD	1 actuation QD
fluticasone/salmeterol (Advair®)	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	1 actuation BID
fluticasone/salmeterol (Airduo RespiClick®)	55/13 mcg, 113/14 mcg, 232/14 mcg per actuation 1 actuation BID	1 actuation BID
budesonide/formoterol (Symbicort®)	80 mcg/4.5 mcg, 160 mcg/4.5 mcg per actuation 2 actuations BID	2 actuations BID
Asthma - Leukotriene modifier (LTRA)		
montelukast (Singulair®)	4 to 10 mg PO QD	10 mg per day
zafirlukast (Accolate®)	10 to 20 mg PO BID	40 mg per day
zileuton ER (Zyflo® CR)	1,200 mg PO BID	2,400 mg per day
Zyflo® (zileuton)	600 mg PO QID	2,400 mg per day
Asthma - Oral corticosteroids		
dexamethasone (Decadron®)	0.75 to 9 mg/day PO in 2 to 4 divided doses	Varies
methylprednisolone (Medrol®)	40 to 80 mg PO in 1 to 2 divided doses	Varies
prednisolone (Millipred®, Orapred ODT®)	40 to 80 mg PO in 1 to 2 divided doses	Varies
prednisone (Deltasone®)	40 to 80 mg PO in 1 to 2 divided doses	Varies

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
EGPA		
methylprednisolone (Medrol)	6.0 mg/day to 0.8 mg/kg/day	Varies
prednisone (Deltasone)	7.5 mg/day to 1 mg/kg/day	Varies
cyclophosphamide*	1-2 mg/kg/day PO or 0.5-1 g/m^2/month IV	See regimen
azathioprine*	2-3 mg/kg PO QD	See regimen
methotrexate*	15 mg/week PO	25 mg/week
mycophenolate mofetil*	1.5-3 g/day PO	3 g/day

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.
**Off-label*

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

Appendix D: General Information
- Asthma:
  - 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.
  - The Global Initiative for Asthma (GINA) guidelines recommend Fasenra be considered as adjunct therapy for patients 12 years of age and older with exacerbations or poor symptom control despite taking at least high dose ICS/LABA and who have eosinophilic biomarkers or need maintenance oral corticosteroids.
  - Patients could potentially meet asthma criteria for both Xolair and Fasenra, though there is insufficient data to support the combination use of multiple asthma biologics.

The combination has not been studied. Approximately 30% of patients in the Nucala MENSA study also were candidates for therapy with Xolair.
    - 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.
    - PDC is a measure of adherence. PDC is calculated as the sum of days covered in a time frame divided by the number of days in the time frame. To achieve a PDC of 0.8, a member must have received their asthma controller therapy for 144 days out of the last 180 days, or approximately 5 months of the last 6 months.
- EGPA:
    - Standard of care for EGPA includes oral glucocorticoids. Induction therapy of prednisone 1 mg/kg/day is recommended for 2-3 weeks followed by gradual tapering to the minimal effective dose. Patients with stable doses of prednisone ≤ 7.5 mg/day are considered to be in remission, as defined by the European League Against Rheumatism (EULAR) and in the pivotal trial. The EGPA Consensus Task Force recommends that patients who are unable to taper prednisone to < 7.5 mg/day after 3-4 months of therapy should be considered for additional immunosuppressant therapy.

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Severe asthma	*Adult and adolescents (12 years and older):* • 30 mg SC every 4 weeks for the first 3 doses, followed by once every 8 weeks thereafter *Pediatric patients 6 - 11 years of age:* • < 35 kg: 10 mg SC every 4 weeks for the first 3 doses, followed by once every 8 weeks thereafter • ≥ 35 kg: 30 mg SC every 4 weeks for the first 3 doses, followed by once every 8 weeks thereafter	See regimen
EGPA	30 mg SC every 4 weeks	30 mg/4 weeks

VI. Product Availability

- Single-dose prefilled syringe with solution for injection: 10 mg/0.5 mL, 30 mg/mL
- Single-dose autoinjector Fasenra Pen with solution for injection: 30 mg/mL

VII. References

1. Fasenra Prescribing Information. Wilmington, DE: AstraZeneca Pharmaceuticals LP; September 2024. Available at: www.fasenra.com. Accessed October 24, 2024.
2. Clinical Pharmacology [database online]. Philadelphia, PA: Elsevier. Updated periodically. Available at: http://www.clinicalkey.com/pharmacology. Accessed November 14, 2024.

Asthma
3. National Asthma Education and Prevention Program: Expert panel report III: Guidelines for the diagnosis and management of asthma. Bethesda, MD: National Heart, Lung, and Blood Institute, 2007. (NIH publication no. 08-4051). Available at http://www.nhlbi.nih.gov/health-pro/guidelines/current/asthma-guidelines. Accessed November 14, 2024.
4. 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: 2301-2317.
5. Global Initiative for Asthma. Global strategy for asthma management and prevention (2024 update). Available from: www.ginasthma.org. Accessed November 14, 2024.
6. Global Initiative for Asthma. Difficult-to-treat and severe asthma in adolescent and adult patients – diagnosis and management, v5.0 November 2024. Available at: www.ginasthma.org. Accessed November 14, 2024.

EGPA
7. Wechsler ME, Nair P, Terrier B, et al. Benralizumab versus mepolizumab for eosinophilic granulomatosis with polyangiitis. N Engl J Med. 2024; 390: 911-921.
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 Care & Research. 2021; 73(8): 1088-1105.
9. Grayson PC, Ponte C, Suppiah R, et al. 2022 American College of Rheumatology/European Alliance of Associations for Rheumatology classification criteria for eosinophilic granulomatosis with polyangiitis. Annals of the Rheumatic Diseases. 2022; 81: 309-314.

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.

HCPCS Codes	Description
J0517	Injection, benralizumab, 1 mg

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created per SDC (adapted from CP.PHAR.373 with the following revisions: for initial approval criteria, modified criteria requiring history of two exacerbations to instead require one exacerbation, added allowance for ER visit, removed intubation option, modified requirement of "LTRA" to "one additional asthma controller medication"). RT4: added criteria for newly approved indication of EGPA.	10.23.24	11.24
1Q 2025 annual review: no significant changes; references reviewed and updated. Per December SDC: added disclaimer statement that NY CHIP Plans should be approved using these criteria.	12.02.24	02.25

Reviews, Revisions, and Approvals	Date	P&T Approval Date
For both indications, extended initial approval duration from 6 to 12 months for this maintenance medication for a chronic condition.	10.21.25	11.25
Per SDC, revised EGPA criteria as follows: added option for eosinophilia to be evidenced by blood eosinophil level ≥ 150 cells/µL prior to treatment with a monoclonal antibody therapy that can alter blood eosinophil levels; modified requirement for "failure of a 4-week trial of a glucocorticoid" to "currently receiving standard therapy for EGPA (i.e., glucocorticoid)".	10.30.25	12.25

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.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions, and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to

recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members, and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

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 refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.