Prior Authorization Criteria

MISSISSIPPI DIVISION OF MEDICAID

Fasenra® (benralizumab) Criteria FOR ASTHMA:

Benralizumab is a subcutaneous humanized interleukin-5 receptor alpha-directed cytolytic monoclonal antibody (IgG1, kappa) used for add-on maintenance treatment of adult and pediatric patients 12 years and older who have severe asthma with an eosinophilic phenotype.

ICD-10 code(s):_____

Initial Authorization: Submission of medical records or prescription claims history documenting the following requirements for the indications below is **required**.

Fasenra will be approved based on **ALL** of the following criteria:

☐ Yes ☐ No Age of patient is within the age range as recommended by the FDA label

-AND-

☐ Yes ☐ No Prescribed by or in consultation with an allergist, immunologist or pulmonologist

-AND-

☐ Yes ☐ No Diagnosis of severe eosinophilic phenotype asthma.

-AND-

☐ Yes ☐ No **All** of the following:

☐ Yes ☐ No Documented eosinophil level > 150 cells/mcL within the past 6 weeks as evidenced by submission of medical records (e.g, chart notes, laboratory values, etc.)

AND

☐ Yes ☐ No Patient has experienced ≥ 2 exacerbations within the last 12 months, requiring at least one of the following despite adherent use (defined as consistent timely fills over 90 days) of controller therapy (i.e., moderate to high dose inhaled corticosteroid (ICS) plus either a long-acting beta-2 agonist (LABA), long-acting muscarinic antagonist (LAMA) or leukotriene modifier (LTRA).

a. Two or more bursts of systemic corticosteroids for at least 3 days each in the previous 12 months
b. Asthma-related emergency treatment (e.g., emergency department visit, hospital admission, or unscheduled physician's office visit for nebulizer or other urgent treatment)
c. Airflow limitation (e.g., after appropriate bronchodilator withheld, forced expiratory volume in 1 second [FEV1] less than 80% predicted [in the face of reduced FEV1/forced vital capacity [FVC] defined as less than the lower limit of normal])

-AND-

☐ Yes ☐ No Fasenra will be used in combination with **one** of the following:

a. **One** preferred high dose combination ICS/LABA

-OR-

b. Combination therapy including **both** of the following:

i. **One** preferred high-dose ICS medication

-AND-

ii. **One** additional preferred asthma controller medication [e.g., LABA, LAMA or LTRA]

-AND-

☐ Yes ☐ No Patient is not receiving Fasenra in combination with **any** of the following:

a. Anti-interleukin-5 therapy (e.g. Nucala , Cinqair)
b. Anti-IgE therapy (e.g. Xolair)

Authorization will be issued for 6 months.

Reauthorization

Fasenra will be approved based on **all** of the following criteria:

☐ Yes ☐ No Patient continues to meet initial authorization criteria

-AND-

☐ Yes ☐ No Documentation of positive clinical response to Fasenra therapy as demonstrated by at least **one** of the following:

(a) Reduction in the frequency of exacerbations
(b) Decreased utilization of rescue medications
(c) Increase in percent predicted FEV1 from pretreatment baseline
(d) Reduction in severity or frequency of asthma-related symptoms (e.g., wheezing, shortness of breath, coughing, etc.)
(e) Reduction in systemic corticosteroid requirements

-AND-

☐ Yes ☐ No Demonstrated adherence to asthma controller therapy that includes either of the following:

a) ICS medication

OR

b) ICS + LABA, LAMA or LTRA medication

Reauthorization will be issued for 12 months.