GOLD COAST HEALTH PLAN TOTAL Care ADVANTAGE℠



# Fasenra *(benralizumab)*

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses (FDA approved indication)** | Fasenra is an interleukin-5 (IL-5) antagonist indicated for severe eosinophilic asthma add-on therapy and for the treatment of adult patients with eosinophilic granulomatosis with polyangiitis (EGPA). |
| **Exclusion Criteria** | Must not be used in combination with other biologic drugs. |
| **Required Medical Information** | For initial coverage of severe eosinophilic asthma:<br><br>Medical records supporting the request, including documentation of prior therapies and responses to treatment must be provided.<br><br>Must have an elevated eosinophil level greater than or equal to 150 cells/mcL within six weeks (prior to the immediate start of treatment with Fasenra) - OR - greater than or equal to 300 cells/mcL in the previous 12 months.<br><br>Must try and fail one ICS/LABA inhaler drug in the past six months (fail is defined as an intolerance or inability to improve the condition on required therapy for at least four weeks).<br><br>For initial coverage of eosinophilic granulomatosis with polyangiitis (EGPA): Medical records supporting the request must be provided and include documentation that the patient has non-severe EGPA (defined as absence of life or organ-threatening manifestations).<br><br>For reauthorization requests for severe eosinophilic asthma: (1) Medical records supporting the request must be provided - (2) Must have documentation of clinical benefit (e.g., decrease in exacerbations, improvement in symptoms, decrease in oral steroid use).<br><br>For reauthorization requests for EGPA: (1) Medical records supporting the request must be provided - (2) Must have documentation of clinical benefit (e.g., decrease in exacerbations, improvement in symptoms, decrease in oral steroid use). |
| **Age Restriction** | None. |
| **Prescriber Restrictions** | Prescriber is a specialist or has consulted with a specialist for the condition being treated. |
| **Coverage Duration** | Initial: One year; reauthorization: two years. Dose will be approved according to the FDA approved labeling or within accepted standards of medical practice. |
| **Other Criteria/Information** | Refer to the Gold Coast Health Plan Medicare Part B Reference and Summary of Evidence document. |

| HCPCS | Description | Billing Units/How Supplied |
|---|---|---|
| J0517 | Fasenra (benralizumab) prefilled syringe | **Billing unit: 1 mg**<br><br>30 mg/mL SD syringe |

| STATUS | DATE REVISED | REVIEW DATE | APPROVED/REVIEWED BY | EFFECTIVE DATE |
|---|---|---|---|---|
| Created | 3/26/2025 | 3/26/2025 | Dawn Shojai, PharmD, Senior Pharmacy Benefit Consultant (PSG) | N/A |
| Approved | N/A | 8/21/2025 | Pharmacy & Therapeutics (P&T) Committee | 8/21/2025 |
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