STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES
BUREAU FOR MEDICAL SERVICES

Office of Pharmacy Services
Prior Authorization Criteria
Fasenra® (benralizumab)
Effective 1/1/2022

Prior Authorization Request Form

FASENRA is an interleukin-5 receptor alpha-directed cytolytic monoclonal antibody (IgG1, kappa) indicated for the add-on maintenance treatment of patients with severe asthma aged 12 years and older, and with an eosinophilic phenotype.

Prior authorization requests for Fasenra may be approved if the following criteria are met:

TREATMENT OF EOSINOPHILIC ASTHMA:

1. Must be prescribed by or in consultation with an allergist, immunologist or pulmonologist; **AND**

2. The patient must be within the age range as recommended by the FDA label and indication; **AND**

3. Patient must have documented adherence to a therapeutic regimen consisting of a LABA + high dose ICS therapy in the last 90 days; **AND**

4. Documentation must be supplied indicating **one** of the following:

    a. A positive sputum test for eosinophilic phenotype asthma with sputum eosinophil level ≥ 3%; **OR**
    b. Asthma with eosinophilic phenotype with blood eosinophil count greater than or equal to 150 cells/mcL within the past 6 weeks or blood eosinophil count greater than or equal to 300 cells/mcL in the past 12 months; **OR**
    c. Claims data that reflect a continual reliance on oral corticosteroid therapy in the last 90 days.

Initial approval of Fasenra for asthma will be for 90 days. Additional therapy shall be approvable with documentation of satisfactory patient response and compliance on inhaled therapy.

References

1.) Fasenra Package Insert 10/2019, 11/2021
2.) LexiComp monograph review 11/18/2019, 11/2021
3.) UpToDate literature review on the treatment of severe asthma in adolescents and adults (11/07/2018)

Updated: DUR meeting 11/17/2021 for effective date 1/1/2022 PS
Original DUR Board Approval: 11/20/2019