SENTARA COMMUNITY PLAN
(MEDICAID)

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: Fasenra® SQ (benralizumab) **(Pharmacy)**

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight (if applicable): _____ **Date weight obtained:** _____

Recommended Dosing:

- ❑ **Asthma, severe eosinophilic**

  Adult and Adolescent Patients 12 Years of Age and Older:

  - 30 mg every 4 weeks for the first 3 doses followed by once every 8 weeks thereafter

  Pediatric Patients 6 Years to 11 Years of Age:

  - Weighing Less Than 35 kg: the recommended dosage is 10 mg every 4 weeks for first 3 doses followed by once every 8 weeks thereafter
  - Weighing 35 kg or More: the recommended dosage is 30 mg every 4 weeks for first 3 doses followed by once every 8 weeks thereafter
- ❑ **Eosinophilic granulomatosis with polyangiitis (EGPA): 30 mg every 4 weeks**
- ❑ **Hypereosinophilic syndrome (HES): 30 mg every 4 weeks**

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***The Health Plan considers the use of concomitant therapy with Cinqair®, Dupixent®, Exdensur®, Nucala®, Tezspire™ and Xolair® to be experimental and investigational. Safety and efficacy of these combinations have NOT been established and will NOT be permitted. In the event a member has an active Cinqair®, Dupixent®, Exdensur®, Nucala®, Tezspire™ or Xolair® authorization on file, all subsequent requests for Fasenra® will NOT be approved.**

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

❑ **Diagnosis: Asthma, severe eosinophilic**

Initial Authorization: 6 months

1. Has the member been approved for Fasenra® previously through the Sentara medical department?
   ❑ Yes ❑ No
2. Is the member 6 years of age or older? ❑ Yes ❑ No
3. Does the member have a diagnosis of severe* asthma? ❑ Yes ❑ No
4. Does the member have asthma with an eosinophilic phenotype defined as blood eosinophils ≥ 150 cells/µL? ❑ Yes ❑ No
5. Will coadministration with another monoclonal antibody be avoided (i.e. omalizumab, mepolizumab, reslizumab, dupilumab, tezepelumab-ekko, depemokimab-ulaa)? ❑ Yes ❑ No
6. Will Fasenra® be used for add-on maintenance treatment in members regularly receiving both (unless otherwise contraindicated) of the following:
   - Medium to high dose inhaled corticosteroids AND
   - An additional controller medication (i.e. long-acting beta agonist, leukotriene modifiers)?

   ❑ Yes ❑ No
7. Has the member had two or more exacerbations in the previous year requiring oral or injectable corticosteroid treatment (in addition to the regular maintenance therapy defined above) or one exacerbation resulting in hospitalization? ❑ Yes ❑ No
8. Does the member have at least one of the following for assessment of clinical status:
   - Use of systemic corticosteroids
   - Use of inhaled corticosteroids
   - Number of hospitalizations, ER visits, or unscheduled visits to healthcare provider due to condition forced expiratory volume in 1 second (FEV1)?

   ❑ Yes ❑ No

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❑ Diagnosis: Asthma, severe eosinophilic

Reauthorization: 12 months. Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

1. Does the member have improvement in asthma symptoms or asthma exacerbations as evidenced by a decrease in one or more of the following:
   - Use of systemic corticosteroids
   - Hospitalizations
   - ER visits
   - Unscheduled visits to healthcare provider
   - Improvement from baseline in forced expiratory volume in 1 second (FEV1)?

   ❑ Yes ❑ No

❑ Diagnosis: Eosinophilic Granulomatosis Polyangiitis (EGPA)

Initial Authorization: 6 months

1. Has the member been approved for Fasenra® previously through the Sentara medical department?
   ❑ Yes ❑ No
2. Is the member 18 years of age or older? ❑ Yes ❑ No
3. Does the member has a diagnosis of EGPA (aka Churg-Strauss Syndrome)? ❑ Yes ❑ No
4. Member has blood eosinophils greater than or equal to 1000 cells/µL or greater than 10% of leukocytes
   ❑ Yes ❑ No
5. Member is currently on maximally tolerated oral corticosteroid therapy or has an intolerance, hypersensitivity or contraindication to oral corticosteroid therapy ❑ Yes ❑ No
6. Member's physician has assessed baseline disease severity utilizing an objective measure/tool (e.g., Birmingham Vasculitis Activity Score [BVAS], history of asthma symptoms and/or exacerbations, duration of remission, rate of relapses) ❑ Yes ❑ No

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❑ Diagnosis: Eosinophilic Granulomatosis Polyangiitis (EGPA)

Reauthorization: 12 months. Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

1. Member has disease response as indicated by improvement in signs and symptoms compared to baseline as evidenced in one or more of the following:
   - ❑ Member is in remission [defined as a Birmingham Vasculitis Activity Score (BVAS) =0 and a prednisone/prednisolone daily dose of ≤ 4 mg]
   - ❑ Decrease maintenance dose of systemic corticosteroids
   - ❑ Improvement in BVAS score compared to baseline
   - ❑ Improvement in asthma symptoms or asthma exacerbations
   - ❑ Improvement in duration of remission or decrease in the rate of relapses

❑ Diagnosis: Hypereosinophilic Syndrome (HES)

Initial Authorization: 6 months

1. Has the member been approved for Fasenra® previously through the Sentara medical department? ❑ Yes ❑ No
2. Is the member 12 years of age or older? ❑ Yes ❑ No
3. Member has been diagnosed with HES (without an identifiable non-hematologic secondary cause (e.g., drug hypersensitivity, parasitic helminth infection, HIV infection, non-hematologic malignancy) or FIP1L1- PDGFRα kinase-positive HES) for at least 6 months prior to starting treatment? ❑ Yes ❑ No
4. Has the member had a history of 2 or more HES flares within the previous 12 months (e.g., documented HES-related worsening of clinical symptoms or blood eosinophil counts requiring an escalation in therapy)? **(submit chart notes and labs confirming diagnosis)** ❑ Yes ❑ No
5. Will this be used in combination with stable doses of at least one other HES therapy, (e.g., oral corticosteroids, immunosuppressive agents, cytotoxic therapy) unless the member cannot tolerate other therapy? ❑ Yes ❑ No
6. Fasenra will not be coadministered with another monoclonal antibody (e.g., omalizumab, reslizumab, mepolizumab, dupilumab, tezepelumab-ekko, depemokimab-ulaa) ❑ Yes ❑ No

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❑ Diagnosis: Hypereosinophilic Syndrome (HES)

Reauthorization: 12 months. Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

1. Does the member have disease response as indicated by a decrease in HES flares from baseline?

   Note: An HES flare is defined as worsening of clinical signs and symptoms of HES or increasing eosinophils (on at least 2 occasions), resulting in the need to increase oral corticosteroids or increase/add cytotoxic or immunosuppressive HES **(submit chart notes)**

   ❑ Yes ❑ No

***Components of severity for classifying asthma as *severe* may include any of the following (not all inclusive):**

- Asthma that remains uncontrolled despite optimized treatment with high-dose ICS-LABA
- Asthma that requires high-dose ICS-LABA to prevent it from being uncontrolled
- Symptoms throughout the day
- Nighttime awakenings, often 7 times per week
- SABA use for symptom control occurs several times per day
- Extremely limited normal activities
- Lung function (percent predicted FEV1) < 60%
- Exacerbations requiring oral systemic corticosteroids are generally more frequent and intense relative to moderate asthma

Eosinophilic Granulomatosis Polyangiitis (EGPA) is defined as all of the following:

- History or presence of asthma
- Blood eosinophil level > 10% or an absolute count > 1000 cells/mm3
- Two or more of the following criteria:
- Histopathologic evidence of eosinophilic vasculitis, perivascular eosinophilic infiltration, or eosinophil rich granulomatous inflammation
- Neuropathy
- Pulmonary infiltrates
- Sinonasal abnormalities
- Cardiomyopathy
- Glomerulonephritis
- Alveolar hemorrhage
- Palpable purpura
- Antineutrophil Cytoplasmic Antibody (ANCA) positivity

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Medication being provided by Specialty Pharmacy - PropriumRx

Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.*

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.*

REVISED/UPDATED/REFORMATTED: ~~2/25/2020; 3/11/2022; 4/26/2022; 6/16/2022;6/16/2022; 11/3/2023;.5/28/2024; 6/19/2024; 3/26/2026; 6/20/2025, 6/18/2026~~**; 8/11/2026**