AETNA BETTER HEALTH®
Coverage Policy/Guideline

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Effective Date:	2/1/2024	Last Review Date:	11/2023

Applies to:	☐Illinois	☐Florida	☐Michigan
	☒New Jersey	☒Maryland	☒Florida Kids
	☒Pennsylvania Kids	☐Virginia	☒Kentucky PRMD

Intent:

The intent of this policy/guideline is to provide information to the prescribing practitioner outlining the coverage criteria for Fasenra under the patient's prescription drug benefit.

Description:

Fasenra is indicated for the add-on maintenance treatment of patients with severe asthma aged 12 years and older, and with an eosinophilic phenotype.

Limitations of Use:

- Not for treatment of other eosinophilic conditions
- Not for relief of acute bronchospasm or status asthmaticus

All other indications are considered experimental/investigational and not medically necessary.

Applicable Drug List:

Fasenra

Policy/Guideline:

Criteria for Initial Approval:

Severe Eosinophilic Phenotype Asthma

A. Submission of the following information is necessary to initiate the prior authorization review:

1. For initial requests:
   a) Member's chart or medical record showing pretreatment blood eosinophil count, dependance on systemic corticosteroids if applicable.
   b) Chart notes, medical record documentation, or claims history supporting previous medications tried including drug, dose, frequency, and duration.
   c) The member is unable to take Dupixent and Xolair for the given diagnosis due to a trial and inadequate treatment response or intolerance, or a contraindication. Documentation is required for approval.

B. Authorization may be granted for members 12 years of age or older when ALL the following criteria are met:

1. Patient has previously received a biologic drug indicated for asthma.
   a) Note: Requests will require that the patient is unable to take Dupixent and Xolair due to a trial and inadequate treatment response or intolerance, or a contraindication.

2. Member will NOT use the requested medication concomitantly with any other biologic drug or targeted synthetic drug for the same indication.

OR

Authorization may be granted for treatment of asthma when ALL the following criteria are met:

1. Member is 12 years of age or older.
2. Medication must be prescribed by or in consultation with an allergist, immunologist, or pulmonologist
3. Member meets EITHER of the following criteria:
   a. Member has a baseline blood eosinophil count of at least 150 cells per microliter; or
   b. Member is dependent on systemic corticosteroids
4. Member has uncontrolled asthma as demonstrated by experiencing at least ONE of the following within the past year:
   a. Two or more asthma exacerbations requiring oral or injectable corticosteroid treatment.
   b. One or more asthma exacerbation resulting in hospitalization or emergency medical care visit.
   c. Poor symptom control (frequent symptoms or reliever use, activity limited by asthma, night waking due to asthma).
5. Member has inadequate asthma control despite current treatment with BOTH of the following medications at optimized doses:
   a. High dose inhaled corticosteroid
   b. Additional controller (i.e., long acting beta$_2$-agonist, long-acting muscarinic antagonist, leukotriene modifier, or sustained-release theophylline)
6. Member will continue to use maintenance asthma treatments (e.g., inhaled corticosteroid, additional controller) in combination with Fasenra.
7. Member will NOT use the requested medication concomitantly with any other biologic drug or targeted synthetic drug for the same indication.

Criteria for Continuation of Therapy:

Severe Eosinophilic Phenotype Asthma

A. Submission of the following information is necessary for the continuation of the prior authorization review:

1. Chart notes or medical record documentation supporting improvement in asthma control

B. Authorization may be granted for treatment of asthma when ALL the following criteria are met:

1. Member is 12 years of age or older
2. Medication must be prescribed by or in consultation with an allergist, immunologist, or pulmonologist
3. Asthma control has improved on Fasenra treatment as demonstrated by at least ONE of the following:
   a. A reduction in the frequency and/or severity of symptoms and exacerbations
   b. A reduction in the daily maintenance oral corticosteroid dose
4. Member will continue to use maintenance asthma treatments (e.g., inhaled corticosteroid, additional controller) in combination with Fasenra.
5. Member will NOT use the requested medication concomitantly with any other biologic drug or targeted synthetic drug for the same indication.

Approval Duration and Quantity Restrictions:

Initial: 6 months

Renewal: 12 months

Initial Quantity Level Limit: 3 syringes for first 84 days

Renewal Quantity Level Limit: 1 syringe per 56 days

References:

1. Fasenra [package insert]. Wilmington, DE: AstraZeneca Pharmaceuticals LP; February 2021.
2. Nair P, Wenzel S, Rabe K, et al. Oral glucocorticoid-sparing effect of benralizumab in severe asthma. N Engl J Med. 2017;376:2448-2458.
3. Global Initiative for Asthma (GINA). Global Strategy for Asthma Management and Prevention. 2021 update. Available at: https://ginasthma.org/wp-content/uploads/2021/05/GINA-Main-Report-2021-V2-WMS.pdf. Accessed March 11, 2022.
4. American Academy of Allergy, Asthma & Immunology (AAAAI) 2020 Virtual Annual Meeting. Available at: https://annualmeeting.aaaai.org/. Accessed March 14, 2022.
5. 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(22): 2301-2317.