



## Drug Quantity Management – Per Days Immunologicals – Fasentra® (benralizumab subcutaneous injection)

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### Product Identifier(s)

**Effective 1/1/23 to 4/10/23:** 111459  
**Effective 4/11/23:** 108427

#### INSTRUCTIONS FOR USE

The following Coverage Policy applies to health benefit plans administered by Cigna Companies. Certain Cigna Companies and/or lines of business only provide utilization review services to clients and do not make coverage determinations. References to standard benefit plan language and coverage determinations do not apply to those clients. Coverage Policies are intended to provide guidance in interpreting certain standard benefit plans administered by Cigna Companies. Please note, the terms of a customer's particular benefit plan document [Group Service Agreement, Evidence of Coverage, Certificate of Coverage, Summary Plan Description (SPD) or similar plan document] may differ significantly from the standard benefit plans upon which these Coverage Policies are based. For example, a customer's benefit plan document may contain a specific exclusion related to a topic addressed in a Coverage Policy. In the event of a conflict, a customer's benefit plan document always supersedes the information in the Coverage Policies. In the absence of a controlling federal or state coverage mandate, benefits are ultimately determined by the terms of the applicable benefit plan document. Coverage determinations in each specific instance require consideration of 1) the terms of the applicable benefit plan document in effect on the date of service; 2) any applicable laws/regulations; 3) any relevant collateral source materials including Coverage Policies and; 4) the specific facts of the particular situation. Coverage Policies relate exclusively to the administration of health benefit plans. Coverage Policies are not recommendations for treatment and should never be used as treatment guidelines. In certain markets, delegated vendor guidelines may be used to support medical necessity and other coverage determinations.

### National Formulary Medical Necessity

This Drug Quantity Management program has been developed to promote the safe, effective, and economic use of Fasentra. If the Drug Quantity Management rule is not met for the requested medication at the point of service, coverage will be determined by the Criteria below. All approvals will be provided for the duration noted below.

#### Drug Quantity Limits

Product	Strength and Form	Retail Maximum Quantity per 56 days	Home Delivery Maximum Quantity per 56 days
Fasentra® (benralizumab subcutaneous injection)	30 mg/mL prefilled syringes	1 syringe	1 syringe
	30 mg/ mL prefilled pens	1 pen	1 syringe

## Criteria

**Cigna covers quantities as medically necessary when the following criteria are met:**

### Fasenra 30 mg/mL prefilled pens and prefilled syringes

1. If the individual is initiating therapy at induction dosing for asthma, as verified by the absence of claims for Fasenra in the past 130 days, approve a one-time override for three prefilled pens or three prefilled syringes for an 84-day supply at retail and at home delivery.

## Conditions Not Covered

Any other exception is considered not medically necessary.

## Background

### Overview

Fasenra, an interleukin-5 receptor alpha (IL-5R $\alpha$ )-directed cytolytic monoclonal antibody, is indicated for **severe asthma** as add-on maintenance treatment of patients  $\geq$  12 years of age who have an eosinophilic phenotype.<sup>1</sup>

Limitations of Use: Fasenra is not indicated for the treatment of other eosinophilic conditions or for the relief of acute bronchospasm/status asthmaticus.

### Dosing

Fasenra is administered as a subcutaneous injection.<sup>1</sup> The recommended dose is 30 mg administered once every 4 weeks for the first 3 doses, and then once every 8 weeks thereafter.

### Availability

Fasenra is available as 30 mg/mL single-dose, prefilled pens and syringes.<sup>1</sup> Each carton contains one pen or syringe.

## References

1. Fasenra® subcutaneous injection [prescribing information]. Wilmington, DE: AstraZeneca; October 2019.

## Revision History

Type of Revision	Summary of Changes	Approval Date
New Policy	--	08/03/2022

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