Connecticut Department of Social Services
Medical Assistance Program **Provider Bulletin 2025-17**
www.ctdssmap.com **May 2025**

TO: **Pharmacy Providers, Physicians, Nurse Practitioners, Physician Assistants, Long Term Care Providers, Clinics, and Hospitals**

RE: **New Fasenra (benralizumab) and Xolair (omalizumab) Prior Authorization Clinical Criteria Requirements**

Effective June 1, 2025, the Department of Social Services (DSS) will implement a Prior Authorization (PA) requirement for prescription benefit coverage of benralizumab injection, marketed as **Fasenra,** and omalizumab injection, marketed as **Xolair**, for HUSKY A, C, and D members.

The U.S. Food and Drug Administration (FDA) approved indications:

Fasenra (benralizumab) injection include:

- Severe asthma (aged 6+)
- Eosinophilic Granulomatosis with Polyangiitis (EPGA) (aged 18+)

Xolair (omalizumab) injection include:

- Moderate to Severe Persistent Asthma (aged 6+)
- Chronic Rhinosinusitis with Nasal Polyps (CRSwNP) (aged 18+)
- IgE-Mediated Food Allergy (aged 1+)
- Chronic Spontaneous Urticaria (CSU) (aged 12+)

Primary treatment guidelines should be followed before a member is prescribed **Fasenra** (benralizumab) or **Xolair** (omalizumab) injection.

Prior Authorization Requirements:

Clinical criteria for PA approval for Fasenra (benralizumab) is as follows:

Severe asthma:

1. The patient must be age 6 or older and;
2. The patient must have a diagnosis of severe asthma with an eosinophilic phenotype and;
3. The patient requires an additional maintenance treatment.

Eosinophilic Granulomatosis with Polyangiitis (EPGA):

1. The patient must be age 18 or older, and,
2. The patient must have a diagnosis of Eosinophilic granulomatosis with Polyangiitis (EPGA).

Clinical criteria for PA approval for **Xolair** (omalizumab) is as follows:

Moderate to Severe Persistent Asthma:

1. The patient must be age 6 or older and;
2. The patient must have been diagnosed with moderate-to-severe persistent asthma and;
3. The patient must have been diagnosed with a positive skin test or in vitro reactivity to a perennial aeroallergen and;
4. The patient must be experiencing symptoms not adequately controlled with inhaled corticosteroids.

Chronic Rhinosinusitis with Nasal Polyps (CRSwNP):

1. The patient must be age 18 or older and;
2. The patient must have been diagnosed with Chronic rhinosinusitis with nasal polyps (CRSwNP) and;
3. The patient must be experiencing inadequate response to nasal corticosteroids and;
4. The patient requires an additional maintenance treatment.

IgE-Mediated Food Allergy:

1. The patient must be age 1 or older and;
2. The patient must have been diagnosed with an IgE-mediated food allergy (Type I), including anaphylaxis and;
3. The patient is in need of reducing allergic reactions, including anaphylaxis, due to

accidental food exposure, while also planning to use food allergen avoidance.

Chronic Spontaneous Urticaria (CSU):

1. The patient must be age 12 or older and;
2. The patient must have been diagnosed with chronic spontaneous urticaria and;
3. The patient must still be symptomatic despite H1 antihistamine treatment.

The new PA forms for **Fasenra (**benralizumab**)** and **Xolair** (omalizumab**)** will be available on the www.ctdssmap.com Web site. From the Home page, go to Information → Publications→Authorization/Certification Forms →**Fasenra (**benralizumab**)** or **Xolair** (omalizumab**)** Prior Authorization Form; or from the Home page, go to Pharmacy Information → Pharmacy Program Publications → **Fasenra (**benralizumab**)** or **Xolair** (omalizumab**)** Prior authorization Form, or click on the following link: Fasenra PA Form, Xolair PA Form.

When the clinical criteria **IS** met, the completed forms should be faxed to one of the numbers listed on the top of the form.

In instances where the individual does **NOT meet these criteria, the prescriber may write a Letter of Medical Necessity to DSS' Medical Director for consideration. Letters of medical necessity can be emailed with the Fasenra or Xolair PA forms to** Rx.LMN@ct.gov **with all relevant information relating to the medical necessity.**

Please note that PAs submitted and approved through the use of the new **Fasenra** (benralizumab) or **Xolair** (omalizumab) Prior Authorization forms will be authorized for a period of twelve (12) months.