tezepelumab-ekko (Tezspire™)

Medicare Advantage Medical Policy #MA-155
Original Effective Date: 01/01/2026
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Applies to all products administered or underwritten by the Health Plan, unless otherwise provided in the applicable contract. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.

When Services May Be Eligible for Coverage

Coverage for eligible medical treatments or procedures, drugs, devices or biological products may be provided only if:

- *Benefits are available in the member's contract/certificate, and*
- *Medical necessity criteria and guidelines are met.*

Based on review of available data, the Health Plan may consider tezepelumab-ekko (Tezspire™)‡ for add-on maintenance treatment of severe asthma to be **eligible for coverage.****

Patient Selection Criteria

Coverage eligibility for tezepelumab-ekko (Tezspire) will be considered for add-on maintenance treatment of severe asthma when the following criteria are met:

Initial Authorization:

I. Requested drug is being used for the treatment of severe asthma; AND
II. Patient is greater than or equal to 12 years of age; AND
III. Requested drug is NOT being used in combination with other monoclonal antibodies typically used to treat asthma [e.g., reslizumab (Cinqair®)‡, omalizumab (Xolair®), benralizumab (Fasenra™), dupilumab (Dupixent®), mepolizumab (Nucala®)]‡; AND
IV. Requested drug is dosed at 210 mg every 4 weeks; AND
V. Patient has received at least 3 consecutive months of combination therapy with BOTH of the following (a AND b):
    a. An inhaled corticosteroid (ICS), [e.g., fluticasone products (Arnuity™ Ellipta®, Armonair™ Respiclick®)‡, mometasone products (Asmanex® Twisthaler®, Asmanex® HFA)‡, flunisolide products (Aersopan™)‡, ciclesonide products (Alvesco®)‡, budesonide products (Pulmicort Flexhaler®)‡, beclomethasone products (QVAR®)‡]; AND
    b. At least ONE of the following (1, 2, 3, OR 4):
        1) Inhaled long-acting beta-agonist (LABA), [e.g., salmeterol products (Serevent® Diskus)‡, olodaterol products (Striverdi® Respimat®)‡, indacaterol products (Arcapta™ Neohaler™)‡]; OR

        Note: Use of a combination inhaler containing both an ICS and a LABA would fulfil the requirement for both criteria a.) and b.) [e.g., fluticasone propionate and salmeterol inhalation powder/aerosol (Advair® Diskus/HFA, fluticasone/salmeterol generics, Wixela™ Inhub, AirDuo™ Respiclick)‡, budesonide and formoterol fumarate inhalation aerosol (Symbicort®)‡, fluticasone furoate and vilanterol inhalation powder (Breo® Ellipta®)‡, mometasone furoate and formoterol fumarate inhalation aerosol (Dulera®)‡).

2) Inhaled long-acting muscarinic antagonist (LAMA), [e.g., tiotropium bromide inhalation spray (Spiriva® Respimat®, Spiriva Handihaler®, Stiolto® Respimat)‡, aclidinium products (Tudorza® Pressair®)‡, glycopyrrolate products (Seebri™ Neohaler, Bevespi™ Aerosphere, Utibron™ Neohaler)‡, umeclidinium products (Incruse® Ellipta, Anoro® Ellipta ‡]; OR
3) Leukotriene receptor antagonist (LTRA), [e.g., montelukast tablets/granules (Singulair®, generics), zafirlukast tablets (Accolate®)]‡; OR
4) Theophylline (Theo-24, Uniphyl, TheoChron ER, generics); AND

VI. Patient's asthma continues to be uncontrolled as defined by ONE of the following (a, b, c, d, OR e):
a) Patient experienced two or more asthma exacerbations requiring treatment with systemic corticosteroids in the previous year; OR
b) Patient experienced one or more asthma exacerbation requiring hospitalization or an Emergency Department (ED) visit in the previous year; OR
c) Patient has a forced expiratory volume in 1 second (FEV_1) < 80% predicted; OR
d) Patient has an FEV_1/forced vital capacity (FVC) < 0.80; OR
e) Patient's asthma worsens upon tapering of oral corticosteroid therapy; AND

VII. Patient meets ONE of the following (a, b, c, OR d):
a) If the patient has a diagnosis of allergic type asthma: Patient has tried and failed (e.g., intolerance or inadequate response) at least 4 months of therapy with omalizumab (Xolair), unless there is clinical evidence or patient history that suggests the use of omalizumab (Xolair) will be ineffective or cause an adverse reaction to the patient; OR
b) If the patient has a diagnosis of oral corticosteroid dependent type asthma: Patient has tried and failed (e.g., intolerance or inadequate response) at least 4 months of therapy with dupilumab (Dupixent), unless there is clinical evidence or patient history that suggests the use of dupilumab (Dupixent) be ineffective or cause an adverse reaction to the patient; OR
c) If the patient has a diagnosis of eosinophilic type asthma: Patient has tried and failed (e.g., intolerance or inadequate response) at least 4 months each of therapy with TWO of the following products: reslizumab (Cinqair), benralizumab (Fasenra), dupilumab (Dupixent), or mepolizumab (Nucala) unless there is clinical evidence or patient history that suggests the use of these products will be ineffective or cause an adverse reaction to the patient; OR
d) Prescriber has indicated that the patient's asthma is not allergic type, eosinophilic type, or oral corticosteroid dependent type.

Re-Authorization

I. Patient received an initial authorization for the requested drug from the plan OR has documentation of authorization for an active course of treatment from previous health plan; AND
II. Requested drug is being used for the treatment of severe asthma; AND

III. Requested drug is NOT being used in combination with other monoclonal antibodies typically used to treat asthma [e.g., reslizumab (Cinqair), omalizumab (Xolair), benralizumab (Fasenra), dupilumab (Dupixent), mepolizumab (Nucala)]; AND
IV. Requested drug is dosed at 210 mg every 4 weeks; AND
V. Patient continues to receive the medications required in criterion V. in the "Initial Criteria"; AND
VI. Patient has responded to Tezspire therapy as determined by the prescriber (e.g., decreased asthma exacerbations; decreased asthma symptoms; decreased hospitalizations, ED/urgent care, or physician visits due to asthma; decreased requirement for oral corticosteroid therapy.)

When Services Are Considered Not Medically Necessary

Based on review of available data, the Health Plan considers the use of tezepelumab-ekko (Tezspire) when the patient has NOT been on the pre-requisite medications for the specified amount of time to be **not medically necessary.****

Based on review of available data, the Health Plan considers the continued use of tezepelumab-ekko (Tezspire) when the patient has NOT responded to tezepelumab-ekko (Tezspire) therapy as determined by the prescriber to be **not medically necessary.****

When Services Are Considered Investigational

Coverage is not available for investigational medical treatments or procedures, drugs, devices or biological products.

Based on review of available data, the Health Plan considers the use of tezepelumab-ekko (Tezspire) when the patient selection criteria are not met (with the exception of those denoted above as **not medically necessary****) to be **investigational.***

Background/Overview

Tezspire is a thymic stromal lymphopoietin (TSLP) blocker, human monoclonal antibody (IgG2λ), indicated for the add-on maintenance treatment of adult and pediatric patients aged 12 years and older with severe asthma. Tezspire is dosed at 210 mg given subcutaneously once every 4 weeks. It's available in 210 mg single dose glass vials, single dose prefilled syringes, or single dose prefilled pens. Unlike the other available dosage forms, the prefilled pens can be administered by the patient or a caregiver, but the glass vials and prefilled syringes must be administered by a healthcare provider.

Asthma

Asthma is a respiratory disorder characterized by increased responsiveness of the trachea and bronchi to various stimuli resulting in the narrowing of the airways, along with mucous secretion. Symptoms vary in severity and intensity and include wheezing, cough and dyspnea. Attacks can be

triggered by exercise, allergens, irritants and viral infections. Based on symptoms, the four levels of asthma severity are:

- Mild intermittent (comes and goes)—you have episodes of asthma symptoms twice a week or less, and you are bothered by symptoms at night twice a month or less; between episodes, however, you have no symptoms and your lung function is normal.
- Mild persistent asthma—you have asthma symptoms more than twice a week, but no more than once in a single day. You are bothered by symptoms at night more than twice a month. You may have asthma attacks that affect your activity.
- Moderate persistent asthma—you have asthma symptoms every day, and you are bothered by nighttime symptoms more than once a week. Asthma attacks may affect your activity.
- Severe persistent asthma—you have symptoms throughout the day on most days, and you are bothered by nighttime symptoms often. In severe asthma, your physical activity is likely to be limited.

Treatment of asthma is based on a step up and step down approach based on the asthma severity and symptoms. Medications include short acting beta agonists for fast relief. Long term treatment centers around the use of ICSs and possible addition of medications such as long acting beta agonists, LTRAs, inhaled long acting muscarinic antagonists, or theophylline. After these more traditional therapies, injectable biologic agents are the next step in treatment. Tezspire is currently the only biologic agent for the treatment of severe asthma that is non-oral corticosteroid dependent, non-eosinophilic, and non-allergic type. There are other biologic agents that treat severe asthma that is oral corticosteroid dependent, eosinophilic, and allergic type. These include Xolair for allergic type, Cinqair, Fasenra, Nucala, and Dupixent for eosinophilic type, and Dupixent for oral corticosteroid dependent asthma. There have not been any head to head studies comparing Tezspire to these other agents. The other biologics listed offer an equally efficacious and more cost-effective option for therapy, where they can be used. However, for non-allergic, non-eosinophilic, and non-oral corticosteroid dependent asthma, Tezspire is an available option.

FDA or Other Governmental Regulatory Approval

U.S. Food and Drug Administration (FDA)

Tezspire is indicated for the add-on maintenance treatment of adult and pediatric patients aged 12 years and older with severe asthma.

Rationale/Source

This medical policy was developed through consideration of peer-reviewed medical literature generally recognized by the relevant medical community, U.S. Food and Drug Administration approval status, nationally accepted standards of medical practice and accepted standards of medical practice in this community, technology evaluation centers, reference to federal regulations, other plan medical policies, and accredited national guidelines.

The efficacy of Tezspire was evaluated in two randomized, double-blind, parallel group, placebo-controlled clinical trials (PATHWAY and NAVIGATOR) of 52 weeks duration. The two trials

enrolled a total of 1,609 patients 12 years of age and older with severe asthma. PATHWAY was a 52-week dose-ranging exacerbation trial that enrolled 550 adult patients with severe asthma who received treatment with tezepelumab-ekko 70 mg subcutaneously every 4 weeks, Tezspire 210 mg subcutaneously every 4 weeks, tezepelumab-ekko 280 mg subcutaneously every 2 weeks, or placebo subcutaneously. Patients were required to have a history of 2 or more asthma exacerbations requiring oral or injectable corticosteroid treatment or 1 asthma exacerbation resulting in hospitalization in the past 12 months. NAVIGATOR was a 52-week exacerbation trial that enrolled 1,061 patients (adult and pediatric patients 12 years of age and older) with severe asthma who received treatment with Tezspire 210 mg subcutaneously every 4 weeks or placebo subcutaneously every 4 weeks. Patients were required to have a history of 2 or more asthma exacerbations requiring oral or injectable corticosteroid treatment or resulting in hospitalization in the past 12 months.

In both PATHWAY and NAVIGATOR, patients were required to have an Asthma Control Questionnaire 6 (ACQ-6) score of 1.5 or more at screening and reduced lung function at baseline [pre-bronchodilator forced expiratory volume in 1 second (FEV_1) below 80% predicted in adults, and below 90% predicted in adolescents]. Patients were required to have been on regular treatment with medium or high-dose inhaled corticosteroids (ICS) and at least one additional asthma controller, with or without oral corticosteroids (OCS). Patients continued background asthma therapy throughout the duration of the trials. In both trials, patients were enrolled without requiring a minimum baseline level of blood eosinophils or fractional exhaled nitric oxide (FeNO).

The primary endpoint for PATHWAY and NAVIGATOR was the rate of clinically significant asthma exacerbations measured over 52 weeks. Clinically significant asthma exacerbations were defined as worsening of asthma requiring the use of or increase in oral or injectable corticosteroids for at least 3 days, or a single depo-injection of corticosteroids, and/or emergency department visits requiring use of oral or injectable corticosteroids and/or hospitalization. In both PATHWAY and NAVIGATOR, patients receiving Tezspire had significant reductions in the annualized rate of asthma exacerbations compared to placebo (0.2 vs. 0.72 and 0.93 vs 2.10, respectively). There were also fewer exacerbations requiring emergency room visits and/or hospitalization in patients treated with Tezspire compared with placebo.

References

1. Tezspire [package insert]. Amgen and AstraZeneca. Thousand Oaks, California and Sodertalje, Sweden. Updated May 2023.
2. Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma (EPR-3). National Heart, Lung, and Blood Institute. www.nhlbi.nih.gov/guidelines/asthma

Policy History

Original Effective Date: 01/01/2026
Current Effective Date: 01/01/2026
10/21/2025 UM Committee review and approval. New policy.
Next Scheduled Review Date: 10/2026

Coding

The five character codes included in the Health Plan Medical Policy Coverage Guidelines are obtained from Current Procedural Terminology (CPT®)‡, copyright 2024 by the American Medical Association (AMA). CPT is developed by the AMA as a listing of descriptive terms and five character identifying codes and modifiers for reporting medical services and procedures performed by physician.

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CPT is a registered trademark of the American Medical Association.

Codes used to identify services associated with this policy may include (but may not be limited to) the following:

Code Type	Code
CPT	No Codes
HCPCS	J2356
ICD-10 Diagnosis	All Related Diagnoses

*Investigational – A medical treatment, procedure, drug, device, or biological product is Investigational if the effectiveness has not been clearly tested and it has not been incorporated into standard medical practice. Any determination we make that a medical treatment, procedure, drug, device, or biological product is Investigational will be based on a consideration of the following:

A. Whether the medical treatment, procedure, drug, device, or biological product can be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA) and whether such approval has been granted at the time the medical treatment, procedure, drug, device, or biological product is sought to be furnished; or
B. Whether the medical treatment, procedure, drug, device, or biological product requires further studies or clinical trials to determine its maximum tolerated dose, toxicity, safety, effectiveness, or effectiveness as compared with the standard means of treatment or diagnosis, must improve health outcomes, according to the consensus of opinion among experts as shown by reliable evidence, including:

1. Consultation with technology evaluation center(s);
2. Credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community; or
3. Reference to federal regulations.

**Medically Necessary (or "Medical Necessity") - Health care services, treatment, procedures, equipment, drugs, devices, items or supplies that a Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

A. In accordance with nationally accepted standards of medical practice;
B. Clinically appropriate, in terms of type, frequency, extent, level of care, site and duration, and considered effective for the patient's illness, injury or disease; and
C. Not primarily for the personal comfort or convenience of the patient, physician or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For these purposes, "nationally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of Physicians practicing in relevant clinical areas and any other relevant factors.

‡ Indicated trademarks are the registered trademarks of their respective owners.

NOTICE: If the Patient's health insurance contract contains language that differs from the Health Plan Medical Policy definition noted above, the definition in the health insurance contract will be relied upon for specific coverage determinations.

NOTICE: Medical Policies are scientific based opinions, provided solely for coverage and informational purposes. Medical Policies should not be construed to suggest that the Health Plan recommends, advocates, requires, encourages, or discourages any particular treatment, procedure, or service, or any particular course of treatment, procedure, or service.

NOTICE: Federal and State law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage.

NOTICE: All codes listed on the Medical Policy require prior authorization. This ensures appropriate utilization and alignment with current clinical guidelines.

Medicare Advantage Members

Established coverage criteria for Medicare Advantage members can be found in Medicare coverage guidelines in statutes, regulations, National Coverage Determinations (NCD)s, and Local Coverage

Determinations (LCD)s. To determine if a National or Local Coverage Determination addresses coverage for a specific service, refer to the Medicare Coverage Database at the following link: https://www.cms.gov/medicare-coverage-database/search.aspx. You may wish to review the Guide to the MCD Search here: https://www.cms.gov/medicare-coverage-database/help/mcd-bene-help.aspx.

When coverage criteria are not fully established in applicable Medicare statutes, regulations, NCDs or LCDs, internal coverage criteria may be developed. This policy is to serve as the summary of evidence, a list of resources and an explanation of the rationale that supports the adoption of this internal coverage criteria.