CarePartners of Connecticut MEDICARE ADVANTAGE

Medical Necessity Guidelines

Medical Benefit Drugs

Tezspire™ (tezepelumab-ekko)

Effective: July 1, 2025

Guideline Type	☒ Prior Authorization ☐ Non-Formulary ☐ Step-Therapy ☐ Administrative

Applies to:

☒ CarePartners of Connecticut Medicare Advantage HMO plans, Fax 617-673-0956

☒ CarePartners of Connecticut Medicare Advantage PPO plans, Fax 617-673-0956

Note: While you may not be the provider responsible for obtaining prior authorization, as a condition of payment you will need to ensure that prior authorization has been obtained.

Overview

Approval of Tezspire was based on the Phase 3 NAVIGATOR and Phase 2b PATHWAY trials. Treatment with Tezspire resulted in a significant reduction in the annualized asthma exacerbation rate at 52 weeks in both trials, with a 56% and 71% decrease compared with placebo, respectively. Furthermore, Tezspire demonstrated a clinically significant reduction in asthma exacerbations in patients with low blood eosinophil levels (i.e. <150 cells/µL), also known as non-eosinophilic asthma.

Food and Drug Administration - Approved Indications

Tezspire (tezepelumab-ekko) is a thymic stromal lymphopoietin (TSLP) blocker, human monoclonal antibody (IgG2λ), indicated for add-on maintenance treatment of adult and pediatric patients aged 12 years and older with severe asthma.

Not for relief of acute bronchospasm or status asthmaticus.

Clinical Guideline Coverage Criteria

The plan may authorize coverage of Tezspire for Members when all the following criteria are met:

1. Documented diagnosis of severe asthma

AND

2. Patient is 12 years of age or older

AND

3. Documentation Tezspire will be used as add-on maintenance therapy

Limitations

- None

Codes

The following code(s) require prior authorization:

Table 1: HCPCS Codes

HCPCS Codes	Description
J2356	Injection, tezepelumab-ekko, 1 mg

References

1. Global Initiative for Asthma. Global Strategy for Asthma Management and Prevention, 2022. Available from: www.ginasthma.org.
2. Chung KF, et al. International ERS/ATS guidelines on definition, evaluation and treatment of severe asthma. European Respiratory Journal 2014 43: 343-373.
3. Menzies-Gow A, et al. Tezepelumab in adults and adolescents with severe, uncontrolled asthma. N Engl J Med.

2021;384(19):1800-1809.
4. Weschler M, et al. Oral corticosteroid-sparing effect of tezepelumab in adults with severe asthma. Abstract presented at: American Thoracic Society International Virtual Conference; May 14–19, 2021.
5. Corren J, et al. Tezepelumab improves patient-reported outcomes in patients with severe, uncontrolled asthma in PATHWAY. Ann Allergy Asthma Immunol. 2021;126(2):187-193.
6. Tezspire (tezepelumab-ekko). Thousand Oaks, CA: Amgen Inc.; May 2023

Approval And Revision History

September 13, 2022: Reviewed by Pharmacy and Therapeutics Committee (P&T)

September 21, 2022: Reviewed by the Medical Policy Approval Committee (MPAC)

Subsequent endorsement date(s) and changes made:

- November 14, 2023: Removed the Limitation The health plan may authorize coverage of Tezspire for up to 12 months if criteria are met and all other indications are considered experimental/investigational and not medically necessary. Minor wording changes (eff 12/1/2023).
- November 2023: Administrative Update in support of calendar year 2024 Medicare Advantage and PDP Final Rule.
- September 2024: Joint Medical Policy and Health Care Services UM Committee review (eff 10/1/24)
- September 10, 2024: No changes.
- June 10, 2025: No changes (eff 7/1/25)
- June 2025: Joint Medical Policy and Health Care Services UM Committee review (eff 7/1/25)

Background, Product and Disclaimer Information

Point32Health prior authorization criteria to be applied to Medicare Advantage plan members is based on guidance from Medicare laws, National Coverage Determinations (NCDs) or Local Coverage Determinations (LCDs). When no guidance is provided, Point32Health uses clinical practice guidance published by relevant medical societies, relevant medical literature, Food and Drug Administration (FDA)-approved package labeling, and drug compendia to develop prior authorization criteria to apply to Medicare Advantage plan members. Medications that require prior authorization generally meet one or more of the following criteria: Drug product has the potential to be used for cosmetic purposes; drug product is not considered as first-line treatment by medically accepted practice guidelines, evidence to support the safety and efficacy of a drug product is poor, or drug product has the potential to be used for indications outside of the indications approved by the FDA. Prior authorization and use of the coverage criteria within this Medical Necessity Guideline will ensure drug therapy is medically necessary, clinically appropriate, and aligns with evidence-based guidelines. We revise and update Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests revisions.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of this guidelines not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to eligibility and benefits on the date of service, coordination of benefits, referral/authorization, utilization management guidelines when applicable, and adherence to plan policies, plan procedures, and claims editing logic.