Clinical Policy: Tezepelumab-ekko (Tezspire)

Reference Number: HIM.PA.176
Effective Date: 03.01.25
Last Review Date: 12.25
Line of Business: HIM

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Tezepelumab-ekko (Tezspire™) is human monoclonal antibody (IgG2λ) that functions as a thymic stromal lymphopoietin blocker.

FDA Approved Indication(s)

Tezspire is indicated for:

- The add-on maintenance treatment of adult and pediatric patients aged 12 years and older with severe asthma.
  Limitation(s) of use: Tezspire is not indicated for the relief of acute bronchospasm or status asthmaticus.
- The add-on maintenance treatment of adult and pediatric patients aged 12 years and older with inadequately controlled chronic rhinosinusitis with nasal polyps (CRSwNP).

Policy/Criteria

Provider must submit documentation (such as office chart notes, lab results, or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation® that Tezspire is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Severe Asthma (must meet all)**:**

1. Diagnosis of asthma;
2. Prescribed by or in consultation with an allergist, immunologist, or pulmonologist;
3. Age ≥ 12 years;
4. Member has experienced ≥ 2 exacerbations within the last 12 months, requiring one of the following (a or b), despite adherent use of controller therapy (i.e., medium- to high-dose inhaled corticosteroid [ICS] plus either a long acting beta-2 agonist [LABA] or leukotriene modifier [LTRA] if LABA contraindication/intolerance):
   a. Oral/systemic corticosteroid treatment (or increase in dose if already on oral corticosteroid);
   b. Urgent care/emergency room (ER) visit or hospital admission;
5. If member has an absolute blood eosinophil count ≥ 150 cells/mcL: Failure of both of the following, each used for ≥ 4 consecutive months, unless clinically significant adverse effects are experienced or all are contraindicated: Dupixent® and Fasenra®;*
   **For Illinois HIM requests, the step therapy requirements above do not apply as of 1/1/2026 per IL HB 5395*
6. Tezspire is prescribed concurrently with an ICS plus either a LABA or LTRA;

7. Tezspire is not prescribed concurrently with Cinqair®, Dupixent, Fasenra, Nucala, or Xolair®;
8. Dose does not exceed 210 mg every 4 weeks.

Approval duration: 12 months

B. Chronic Rhinosinusitis with Nasal Polyposis (must meet all)**:**
1. Diagnosis of CRSwNP with documentation of all of the following (a, b, and c):
   a. Presence of nasal polyps;
   b. Disease is bilateral;
   c. Member has experienced signs and symptoms (e.g., nasal congestion/blockage/ obstruction, loss of smell, rhinorrhea) for ≥ 12 weeks;
2. Prescribed by or in consultation with an allergist, immunologist, or otolaryngologist;
3. Age ≥ 12 years;
4. Member has required the use of systemic corticosteroids for symptom control within the last 2 years, unless contraindicated or clinically significant adverse effects are experienced *(see Appendix B for examples)*;*
   **For Illinois HIM requests, the step therapy requirements above do not apply as of 1/1/2026 per IL HB 5395*
5. Failure of maintenance therapy with two intranasal corticosteroids, one of which must be Xhance™* in adults, each used for ≥ 4 weeks, unless contraindicated or clinically significant adverse effects are experienced *(see Appendix B for examples)*;
   **For Illinois HIM requests, the step therapy requirement for use of Xhance above does not apply as of 1/1/2026 per IL HB 5395; any two intranasal corticosteroids may be tried*
6. Failure of a ≥ 4 consecutive month trial of Dupixent, used at up to maximally indicated doses, unless contraindicated or clinically significant adverse effects are experienced;^
   **Prior authorization may be required for Dupixent*
   ^For Illinois HIM requests, the step therapy requirements above do not apply as of 1/1/2026 per IL HB 5395
7. Tezspire is prescribed concurrently with an intranasal corticosteroid, unless contraindicated or clinically significant adverse effects are experienced *(see Appendix B for examples)*;
8. Tezspire is not prescribed concurrently with Cinqair, Dupixent, Fasenra, Nucala, or Xolair;
9. Dose does not exceed 210 mg every 4 weeks.

Approval duration: 12 months

C. Other diagnoses/indications (must meet 1 or 2)**:**
1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: HIM.PA.33 for health insurance marketplace; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: HIM.PA.103 for health insurance marketplace; or

2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: HIM.PA.154 for health insurance marketplace.

II. Continued Therapy

A. Severe Asthma (must meet all)**:**

1. Member meets one of the following (a or b):
   a. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
   b. Member is currently receiving medication and is enrolled in a state and product with continuity of care regulations (*refer to state specific addendums for CC.PHARM.03A and CC.PHARM.03B);*
2. Demonstrated adherence to asthma controller therapy (an ICS plus either a LABA or LTRA) as evidenced by proportion of days covered (PDC) of 0.8 in the last 6 months (i.e., member has received asthma controller therapy for at least 5 of the last 6 months);
3. Member is responding positively to therapy (examples may include but are not limited to: reduction in exacerbations or corticosteroid dose, improvement in forced expiratory volume over one second since baseline, reduction in the use of rescue therapy);
4. Tezspire is not prescribed concurrently with Cinqair, Dupixent, Fasenra, Nucala, or Xolair;
5. If request is for a dose increase, new dose does not exceed 210 mg every 4 weeks.

Approval duration: 12 months

B. Chronic Rhinosinusitis with Nasal Polyposis (must meet all)**:**

1. Member meets one of the following (a or b):
   a. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
   b. Member is currently receiving medication and is enrolled in a state and product with continuity of care regulations (*refer to state specific addendums for CC.PHARM.03A and CC.PHARM.03B)*;
2. Demonstrated adherence to an intranasal corticosteroid, unless contraindicated or clinically significant adverse effects are experienced;
3. Member is responding positively to therapy (examples may include but are not limited to: reduced nasal polyp size, reduced need for systemic corticosteroids, improved sense of smell, improved quality of life);
4. Failure of a ≥ 4 consecutive month trial of Dupixent, used at up to maximally indicated doses, unless contraindicated or clinically significant adverse effects are experienced;^
   **Prior authorization may be required for Dupixent*
   ^For Illinois HIM requests, the step therapy requirements above do not apply as of 1/1/2026 per IL HB 5395
5. Tezspire is not prescribed concurrently with Cinqair, Dupixent, Fasenra, Nucala, or Xolair;
6. If request is for a dose increase, new dose does not exceed 210 mg every 4 weeks.

Approval duration: 12 months

C. Other diagnoses/indications (must meet 1 or 2)**:**
1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: HIM.PA.33 for health insurance marketplace; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: HIM.PA.103 for health insurance marketplace; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: HIM.PA.154 for health insurance marketplace.

III. Diagnoses/Indications for which coverage is NOT authorized:

A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies – HIM.PA.154 for health insurance marketplace or evidence of coverage documents;

B. Acute bronchospasm or status asthmaticus.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

CRSwNP: chronic rhinosinusitis with nasal polyps
FDA: Food and Drug Administration
GINA: Global Initiative for Asthma
ICS: inhaled corticosteroid
LABA: long-acting beta2 agonist
LTRA: leukotriene modifier
PDC: proportion of days covered

Appendix B: Therapeutic Alternatives

This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent for all relevant lines of business and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Asthma - ICS (medium – high dose)		
Qvar® (beclomethasone)	> 200 mcg/day 40 mcg, 80 mcg per actuation 1-4 actuations BID	4 actuations BID
budesonide (Pulmicort®)	> 400 mcg/day 90 mcg, 180 mcg per actuation 2-4 actuations BID	2 actuations BID
Alvesco® (ciclesonide)	> 160 mcg/day 80 mcg, 160 mcg per actuation 1-2 actuations BID	2 actuations BID

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
fluticasone propionate (Flovent®)	> 250 mcg/day 44-250 mcg per actuation 2-4 actuations BID	2 actuations BID
Arnuity Ellipta® (fluticasone furoate)	200 mcg/day 100 mcg, 200 mcg per actuation 1 actuation QD	1 actuation QD
Asmanex® (mometasone)	> 200 mcg/day HFA: 100 mcg, 200 mcg per actuation Twisthaler: 110 mcg, 220 mcg per actuation 1-2 actuations QD to BID	2 inhalations BID
Asthma - LABA		
Serevent® (salmeterol)	50 mcg per dose 1 inhalation BID	1 inhalation BID
Asthma - Combination products (ICS + LABA)		
Dulera® (mometasone/ formoterol)	100/5 mcg, 200/5 mcg per actuation 2 actuations BID	4 actuations per day
Breo Ellipta® (fluticasone/vilanterol)	100/25 mcg, 200/25 mcg per actuation 1 actuation QD	1 actuation QD
fluticasone/salmeterol (Advair®)	Diskus: 100/50 mcg, 250/50 mcg, 500/50 mcg per actuation HFA: 45/21 mcg, 115/21 mcg, 230/21 mcg per actuation 1 actuation BID	1 actuation BID
fluticasone/salmeterol (Airduo RespiClick®)	55/13 mcg, 113/14 mcg, 232/14 mcg per actuation 1 actuation BID	1 actuation BID
budesonide/formoterol (Symbicort®)	80 mcg/4.5 mcg, 160 mcg/4.5 mcg per actuation 2 actuations BID	2 actuations BID
Asthma - LTRA		
montelukast (Singulair®)	4 to 10 mg PO QD	10 mg per day
zafirlukast (Accolate®)	10 to 20 mg PO BID	40 mg per day
zileuton ER (Zyflo® CR)	1,200 mg PO BID	2,400 mg per day
Zyflo® (zileuton)	600 mg PO QID	2,400 mg per day
Asthma - Oral corticosteroids		
dexamethasone (Decadron®)	0.75 to 9 mg/day PO in 2 to 4 divided doses	Varies
methylprednisolone (Medrol®)	40 to 80 mg PO in 1 to 2 divided doses	Varies
prednisolone (Millipred®, Orapred ODT®)	40 to 80 mg PO in 1 to 2 divided doses	Varies
prednisone (Deltasone®)	40 to 80 mg PO in 1 to 2 divided doses	Varies

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Asthma - Biologics		
Dupixent (dupilumab)	*Adults and adolescents (12 years and older)*: Initial dose of 400 mg SC followed by 200 mg SC every other week; or Initial dose of 600 mg SC followed by 300 mg SC every other week *Adolescents 6-11 years of age*: • Body weight 15 to < 30 kg: Initial dose and subsequent dose of 300 mg SC every four weeks • Body weight ≥ 30 kg: Initial dose and subsequent dose of 200 mg SC every other week	See regimen
Fasenra (benralizumab)	*Adult and adolescents (12 years and older):* • 30 mg SC every 4 weeks for the first 3 doses, followed by once every 8 weeks thereafter *Pediatric patients 6 - 11 years of age:* • < 35 kg: 10 mg SC every 4 weeks for the first 3 doses, followed by once every 8 weeks thereafter • ≥ 35 kg: 30 mg SC every 4 weeks for the first 3 doses, followed by once every 8 weeks thereafter	See regimen
CRSwNP		
Intranasal corticosteroids		
beclomethasone (Beconase AQ®, Qnasl®)	1-2 sprays IN BID	2 sprays/nostril BID
budesonide (Rhinocort® Aqua, Rhinocort®)	128 mcg IN QD or 200 mcg IN BID	1-2 inhalations/ nostril/day
flunisolide	2 sprays IN BID	2 sprays/nostril TID
fluticasone propionate (Flonase®)	1-2 sprays IN BID	2 sprays/nostril BID
mometasone (Nasonex®)	2 sprays IN BID	2 sprays/nostril BID
Omnaris®, Zetonna® (ciclesonide)	Omnaris: 2 sprays IN QD Zetonna: 1 spray IN QD	Omnaris: 2 sprays/ nostril/day Zetonna: 2 sprays/ nostril/day

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
triamcinolone (Nasacort®)	2 sprays IN QD	2 sprays/ nostril/day
Xhance™ (fluticasone propionate)	1 to 2 sprays (93 mcg/spray) to nostril IN BID	744 mcg/day
Oral corticosteroids		
dexamethasone (Decadron®)	0.75 to 9 mg/day PO in 2 to 4 divided doses	Varies
methylprednisolone (Medrol®)	4 to 48 mg PO in 1 to 2 divided doses	Varies
prednisolone (Millipred®, Orapred ODT®)	5 to 60 mg PO in 1 to 2 divided doses	Varies
prednisone (Deltasone®)	5 to 60 mg PO in 1 to 2 divided doses	Varies

Therapeutic alternatives are listed as Brand name® (generic) when the drug is available by brand name only and generic (Brand name®) when the drug is available by both brand and generic.

Appendix C: Contraindications/Boxed Warnings

- Contraindication(s): known hypersensitivity to tezepelumab-ekko or excipients
- Boxed warning(s): none

Appendix D: General Information

- The phase 3 pivotal study for Tezspire, NAVIGATOR, required a history of 2 or more asthma exacerbations requiring oral or injectable corticosteroid treatment or resulting in hospitalization in the past 12 months. The primary endpoint of reduction in the annualized asthma exacerbation rate at 52 weeks was met, with a 56% decrease compared with placebo. Patients were required to have been on regular treatment with medium or high-dose ICS and at least one additional asthma controller, with or without oral corticosteroids. Patients continued background asthma therapy throughout the duration of the trial.
- The definition of the primary endpoint marker of clinically significant asthma exacerbation was 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.
- The Global Initiative for Asthma (GINA) guidelines recommend Tezspire be considered as adjunct therapy for patients 12 years of age and older with uncontrolled severe asthma despite optimized maximal therapy and with severe exacerbations in the last year.
- PDC is a measure of adherence. PDC is calculated as the sum of days covered in a time frame divided by the number of days in the time frame. To achieve a PDC of 0.8, a member must have received their asthma controller therapy for 144 days out of the last 180 days, or approximately 5 months of the last 6 months.

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Asthma, CRSwNP	210 mg SC once every 4 weeks *Note: The vial and pre-filled syringe are intended for administration by a healthcare provider. The pre-filled pen can be administered by patients/caregivers or healthcare providers.*	210 mg/4 weeks

VI. Product Availability

- Single-dose vial: 210 mg/1.91 mL (110 mg/mL)
- Single-dose pre-filled syringe: 210 mg/1.91 mL (110 mg/mL)
- Single-dose pre-filled pen: 210 mg/1.91 mL (110 mg/mL)

VII. References

1. Tezspire Prescribing Information. Thousand Oaks, CA: Amgen; October 2025. Available at: https://www.tezspire.com. Accessed November 18, 2025.
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Asthma

4. National Asthma Education and Prevention Program: Expert panel report III: Guidelines for the diagnosis and management of asthma. Bethesda, MD: National Heart, Lung, and Blood Institute, 2007. (NIH publication no. 08-4051). Available at http://www.nhlbi.nih.gov/health-pro/guidelines/current/asthma-guidelines.
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CRSwNP

10. Rosenfeld RM, Piccirillo JF, Chandrasekhar SS, et al. Clinical practice guideline (update): adult sinusitis. Otolaryngology–Head and Neck Surgery 2015, Vol. 152(2S) S1–S39.
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13. Han JK, Bosson JV, Cho SH, et al. Multidisciplinary consensus on a stepwise treatment algorithm for management of chronic rhinosinusitis with nasal polyps. Int Forum Allergy Rhinol. 2021;1-10. Available at: https://onlinelibrary.wiley.com/doi/10.1002/alr.22851. Accessed October 25, 2022.
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Coding Implications
Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

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

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created: adapted from CP.PHAR.576 [per December SDC, added redirection to Dupixent, Fasenra, and Nucala for members with absolute blood eosinophil count ≥ 150 cells/mcL].	12.02.24	02.25
Removed continued therapy redirection to Dupixent, Fasenra, and Nucala; added step therapy bypass for IL HIM per IL HB 5395.	08.28.25	11.25
Per SDC request, removed redirection to Nucala. Revised initial approval duration from 6 to 12 months. RT4: added new indication for CRSwNP per updated prescribing information.	11.18.25	12.25

Important Reminder
This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions, and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members, and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note:
For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.