Generic Name: Tezepelumab-ekko

Therapeutic Class or Brand Name: Tezspire

Applicable Drugs (if Therapeutic Class): N/A

Preferred: N/A

Non-preferred: N/A

Date of Origin: 4/28/2022

Date Last Reviewed / Revised: 7/1/2024

PRIOR AUTHORIZATION CRITERIA

(May be considered medically necessary when criteria I and VI are met)

I. Documented diagnosis of severe asthma and must meet criteria A:
   A. Documentation that the patient has been on a minimum of a six-month trial of a high-dose inhaled corticosteroid (ICS) used in combination with a long-acting inhaled beta-2 agonist (LABA)

II. Documentation that the patient's asthma symptoms are poorly controlled despite therapy AND meets at least one of the following criteria a through e:
   A. Poor symptom control (eg, Asthma Control Questionnaire [ACQ] score consistently greater than 1.5 or Asthma Control Test [ACT] score consistently less than 20)
   B. Two or more asthma exacerbations requiring systemic corticosteroids within the past 12 months.
   C. One or more asthma exacerbations requiring emergency treatment (ie, hospitalization, mechanical ventilation, emergency room visit) within the past 12 months.
   D. Worsening asthma when oral corticosteroids are tapered.
   E. Baseline forced expiratory volume in one second (FEV1) less than 80% predicted.

III. Minimum age requirement: 12 years old.

IV. Treatment must be prescribed by or in consultation with an allergist, immunologist, or pulmonologist.

V. Request is for a medication with the appropriate FDA labeling, or its use is supported by current clinical practice guidelines.

VI. Refer to the plan document for the list of preferred products. If the requested agent is not listed as a preferred product, must have documented treatment failure or contraindication to the preferred product(s).

EXCLUSION CRITERIA

- Treatment of acute bronchospasm or status asthmaticus.
- Concurrent use with other anti-asthma monoclonal antibodies (ie, Cinqair (reslizumab), Dupixent (dupilumab), Fasenra (benralizumab), Nucala (mepolizumab), Xolair (omalizumab)).

Other Criteria

- N/A

Quantity / Days Supply Restrictions

- One 210 mg syringe, pen, or vial every 4 weeks.

Approval Length

- **Authorization:** 6 months
- **Re-Authorization:** An updated letter of medical necessity or progress notes showing that current medical necessity criteria are met and that the medication is effective.

Appendix

- N/A

References

1. Tezspire. Prescribing information. Amgen Inc; 2023. Accessed June 20, 2024. https://den8dhaj6zs0e.cloudfront.net/50fd68b9-106b-4550-b5d0-12b045f8b184/e306dc06-d580-4457-b15f-9f28545ad63a/e306dc06-d580-4457-b15f-9f28545ad63a_viewable_rendition__v.pdf
2. Expert Panel Working Group of the National Heart, Lung, and Blood Institute (NHLBI) administered and coordinated National Asthma Education and Prevention Program Coordinating Committee (NAEPPCC), Cloutier MM, Baptist AP, et al. 2020 Focused updates to the asthma management guidelines: A report from the National Asthma Education and Prevention Program Coordinating Committee Expert Panel Working Group [published correction appears in J Allergy Clin Immunol. 2021 Apr;147(4):1528-1530]. J Allergy Clin Immunol. 2020;146(6):1217-1270. doi:10.1016/j.jaci.2020.10.003
3. Global Initiative for Asthma. Difficult-to-treat & severe asthma in adolescent and adult patients: diagnosis and management V4.0. August 2023. Accessed October 15, 2023. https://ginasthma.org/severeasthma/