EVH Clinical Guideline 5076.CC for Tezspire (Tezepelumab)

Guideline Number: EVH_CG_5076.CC	**Applicable Codes**	
"Evolent" refers to Evolent Health LLC and Evolent Specialty Services, Inc. 		
Original Date: September 2023	**Last Revised Date:** January 2026	**Implementation Date:** March 2026

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STATEMENT

General Information

- *It is the policy of the Health Plan to maintain a prior authorization process that promotes appropriate utilization of specific drugs with potential for misuse or limited indications. This process involves a review using Food and Drug Administration (FDA) criteria to make a determination of Medical Necessity, and approval by the Medical Policy Committee.*
- *If the established criteria are not met, the request is referred to a Medical Director for review, if required for the plan and level of request.*

Purpose

The purpose of this guideline is to define the prior authorization process for Tezspire (tezepelumab).

Scope

This guideline applies to all practitioners who are involved in providing the requested drug. This guideline is specific to the Health Plan's medical benefit.

INITIAL REVIEW CRITERIA

The request must meet all of the criteria listed under the diagnosis-specific sections below.

Asthma

- Must be prescribed by or in consultation with an allergist, immunologist, or pulmonologist
- Must be age 12 years or older
- Must have chart documentation supporting a diagnosis of severe, persistent asthma
- Must have asthma symptoms that have not been adequately controlled on an optimized medication regimen, defined by ONE of the following:
  - Hospitalization or emergency visit for asthma in the past year
  - Requirement for systemic (oral, parenteral) corticosteroids to control exacerbations of asthma on 2 occurrences in the past year
  - Poor symptom control (e.g., frequent symptoms or reliever use, activity limited by asthma, night waking due to asthma)
- Must have tried a high dose inhaled corticosteroid (see **table 1 in Appendix**) in combination with ONE of the following:
  - Inhaled long-acting beta agonist
  - Inhaled long-acting muscarinic antagonist

- Leukotriene receptor antagonist
- Theophylline

- Must have documentation or attestation from the provider of the following:
  - Will not be used concurrently with Xolair, Dupixent, or another anti-IL5 biologic (e.g., Nucala, Cinqair, Fasenra) when used for the treatment of asthma
  - The member will continue to use maintenance asthma treatments (e.g., inhaled corticosteroid, additional controller) in combination with the requested medication
- Must be prescribed at a dose within the manufacturer's dosing guidelines (based on diagnosis, weight, etc.) listed in the FDA approved labeling

Chronic Rhinosinusitis with Nasal Polyps (CRSwNP)

- Must be age 12 years or older
- Prescribed by an allergist, immunologist, or otolaryngologist (ENT)
- Must have a diagnosis of bilateral nasal polyps with documentation of at least ONE of the following:
  - Bilateral nasal endoscopy, anterior rhinoscopy, or computed tomography (CT) showing polyps reaching below the lower border of the middle turbinate or beyond in each nostril
  - Meltzer Clinical Score of 2 or higher in both nostrils
  - Total endoscopic nasal polyp score (NPS) of at least 5 with a minimum score of 2 for each nostril
- Must have documentation showing symptoms of nasal blockage, congestion, or obstruction plus ONE additional symptom below:
  - Rhinorrhea (anterior/posterior)
  - Reduction or loss of smell
  - Facial pain or pressure
- Documentation of an adequate trial of nasal corticosteroids for at least TWO months with an inadequate response or significant side effects/toxicity or have a contraindication to these therapies
- Must have documentation or attestation from the provider of the following:
  - That the requested medication will not be used with another biologic or targeted synthetic drug for nasal polyps, such as Nucala (mepolizumab)
  - That the requested medication will be used as an add-on maintenance treatment (e.g., nasal corticosteroids)
- Must be prescribed at a dose within the manufacturer's dosing guidelines (based on diagnosis, weight, etc.) listed in the FDA approved labeling

REAUTHORIZATION CRITERIA

All prior authorization renewals are reviewed on an annual basis to determine the Medical Necessity for continuation of therapy. The request must meet all of the criteria listed below.

Asthma

- The member's condition has improved based upon the prescriber's assessment while on therapy, including ONE of the following:
  - A reduction in the frequency and/or severity of symptoms and exacerbation
  - A reduction in the daily maintenance oral corticosteroid dose
- Must have documentation or attestation from the provider of the following:
  - Member will not use the requested medication with another biologic or targeted synthetic drug for asthma, such as Dupixent, Fasenra, Nucala, or Xolair
  - Member must continue to use maintenance asthma treatments (e.g., inhaled corticosteroids) in combination with tezepelumab
- Must be prescribed at a dose within the manufacturer's dosing guidelines (based on diagnosis, weight, etc.) listed in the FDA approved labeling

Chronic Rhinosinusitis with Nasal Polyps (CRSwNP)

- Must have recent chart note documentation showing a beneficial response to treatment, as evidenced by improvement in signs and symptoms of CRSwNP (e.g., improvement in nasal congestion, nasal polyp size, loss of smell, anterior or posterior rhinorrhea, sinonasal inflammation, hyposmia and/or facial pressure or pain or reduction in corticosteroid use)
- Must be prescribed at a dose within the manufacturer's dosing guidelines (based on diagnosis, weight, etc.) listed in the FDA-approved labeling
- Must have documentation or attestation from the provider of the following:
  - That the member will continue to use a daily intranasal corticosteroid while being treated with the requested medication, unless contraindicated or not tolerated
  - Member will not use another biologic or targeted synthetic drug for CRSwNP, such as Xolair (omalizumab)

APPROVAL DURATIONS

Initial Authorization	Up to 1 year
Reauthorization	Same as initial

APPENDIX

Table 1: High daily metered doses of inhaled corticosteroids – adapted from GINA 2025 guidelines

Inhaled Corticosteroid (ICS)	Total daily ICS high dose (mcg) – ages 6 to 11 years	Total daily ICS high dose (mcg) ages ≥12 years
Beclometasone diproprionate (pMDI, standard particle, HFA)	>400	>1000
Beclometasone diproprionate (DPI or pMDI, extrafine particle, HFA)	>200	>400
Budesonide (DPI, or pMDI, standard particle, HFA)	>400	>800
Budesonide (nebules)	>1000	N/A
Ciclesonide (pMDI, extrafine particle, HFA)	>160	>320
Fluticasone furoate (DPI)	N/A	200
Fluticasone propionate (DPI, or pMDI, standard particle, HFA)	>200	>500
Mometasone furoate (pMDI, standard particle, HFA)	200	>400

CODING AND STANDARDS

Codes

Code	Brand	Description
J2356	Tezspire	Injection, tezepelumab-ekko, 1 mg

Applicable Lines of Business

☐	CHIP (Children's Health Insurance Program)
☐	Commercial
☐	Exchange/Marketplace
☒	Medicaid
☐	Medicare Advantage

BACKGROUND

Tezspire (tezepelumab) is indicated for the following:

- the add-on maintenance treatment of adult and pediatric patients aged 12 years and older with severe asthma
- the add-on maintenance treatment of adult and pediatric patients aged 12 years and older with inadequately controlled chronic rhinosinusitis with nasal polyps (CRSwNP)

Definitions

Severe Asthma – As defined by the European Respiratory Society (ERS)/American Thoracic Society (ATS), severe asthma is "asthma that requires treatment with high dose inhaled corticosteroids […] plus a second controller (and/or systemic corticosteroids) to prevent it from becoming 'uncontrolled' or which remains 'uncontrolled' despite this therapy".

POLICY HISTORY

Date	Summary
January 2026	• Updated initial asthma criteria • Added CRSwNP criteria
September 2023	• New Guideline

LEGAL AND COMPLIANCE

Guideline Approval

Committee

Reviewed / Approved by Evolent Administrative Services Medical Policy Committee

Disclaimer

Evolent Clinical Guidelines do not constitute medical advice. Treating health care professionals are solely responsible for diagnosis, treatment, and medical advice. Evolent uses Clinical Guidelines in accordance with its contractual obligations to provide utilization management. Coverage for services varies for individual members according to the terms of their health care coverage or government program. Individual members' health care coverage may not utilize some Evolent Clinical Guidelines. Evolent clinical guidelines contain guidance that requires prior authorization and service limitations. A list of procedure codes, services or drugs may not be all inclusive and does not imply that a service or drug is a covered or non-covered service or drug. Evolent reserves the right to review and update this Clinical Guideline in its sole discretion. Notice of any changes shall be provided as required by applicable provider agreements and laws or regulations. Members should contact their Plan customer service representative for specific coverage information.

REFERENCES

1. Tezspire [Prescribing Information]. Thousand Oaks, CA: Amgen Inc. and AstraZeneca; October 2025.
2. 2025 Global Initiative for Asthma (GINA) Report: Global Strategy for Asthma Management and Prevention. https://ginasthma.org/2025-gina-strategy-report/
3. Holguin F, Cardet JC, Chung KF, et al. Management of severe asthma: a European Respiratory Society/American Thoracic Society guideline. Eur Respir J 2020; 55: 1900588 [https://doi.org/ 10.1183/13993003.00588-2019].