AETNA BETTER HEALTH®
Coverage Policy/Guideline

Name:	Tezspire	Page:	1 of 3
Effective Date:	8/19/2024	Last Review Date:	7/23/2024

Applies to:	☐New Jersey	☒Maryland	☒Florida Kids
	☒Pennsylvania Kids	☐Virginia	☒Kentucky PRMD

Intent:

The intent of this policy/guideline is to provide information to the prescribing practitioner outlining the coverage criteria for Tezspire under the patient's prescription drug benefit.

Description:

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

Limitations of use: Not for relief of acute bronchospasm or status asthmaticus.

All other indications are considered experimental/investigational and not medically necessary.

Note: If the member is a current smoker or vaper, they should be counseled on the harmful effects of smoking and vaping on pulmonary conditions and available smoking and vaping cessation options.

Applicable Drug List:

Tezspire

Policy/Guideline:

I. Documentation

Submission of the following information is necessary to initiate the prior authorization review:

A. Initial requests:
   1. Chart notes, medical record documentation, or claims history supporting previous medications tried including drug, dose, frequency, and duration.
   2. The member is unable to take Dupixent and Xolair for the given diagnosis due to a trial and inadequate treatment response or intolerance, or a contraindication. Documentation is required for approval.
   3. Member will NOT use the requested medication concomitantly with any other biologic drug or targeted synthetic drug for the same indication.

B. Continuation requests:
   1. Chart notes or medical record documentation supporting improvement in asthma control.
   2. Member will NOT use the requested medication concomitantly with any other biologic drug or targeted synthetic drug for the same indication.

II. Prescriber Specialties

This medication must be prescribed by or in consultation with an allergist / immunologist or pulmonologist.

III. Criteria for Initial Approval:

A. Authorization of 6 months may be granted for members 12 years of age or older who have previously received a biologic drug indicated for asthma in the past year.

OR

B. Authorization may be granted for treatment of severe asthma when ALL the following criteria are met:
   1. Member is 12 years of age or older.
   2. Member has uncontrolled asthma as demonstrated by experiencing at least ONE of the following within the past year:
      i. Two or more asthma exacerbations requiring oral or injectable corticosteroid treatment.
      ii. One or more asthma exacerbation resulting in hospitalization or emergency medical care visit.
      iii. Poor symptom control (frequent symptoms or reliever use, activity limited by asthma, night waking due to asthma).
   3. Member has inadequate asthma control despite current treatment with BOTH of the following medications at optimized doses:
      i. High dose inhaled corticosteroid
      ii. Additional controller (i.e., long acting beta2-agonist, long-acting muscarinic antagonist, leukotriene modifier, or sustained-release theophylline)
   4. Member will continue to use maintenance asthma treatments (e.g., inhaled corticosteroid, additional controller) in combination with requested medication.

IV. Criteria for Continuation of Therapy

Authorization of 12 months may be granted for members for continuation of treatment of severe asthma when ALL the following criteria are met:

A. Member is 12 years of age or older.
B. Asthma control has improved on the requested medication as demonstrated by at least one of the following:
   1. A reduction in the frequency and/or severity of symptoms and exacerbations
   2. A reduction in the daily maintenance oral corticosteroid dose
C. Member will continue to use maintenance asthma treatments (e.g., inhaled corticosteroid, additional controller) in combination with the requested medication.

Approval Duration and Quantity Restrictions:

Initial Approval: 6 months

Renewal Approval: 12 months

Quantity Level Limit: 1 vial, syringe, or pen per 28 days

References:

1. Tezspire [package insert]. Thousand Oaks, CA: Amgen Inc.; May 2023.
2. Global Initiative for Asthma (GINA). Global Strategy for Asthma Management and Prevention. 2023 update. Available at: https://ginasthma.org/wp-content/uploads/2023/07/GINA-Full-Report-23_07_06-WMS.pdf. Accessed March 8, 2024.
3. Cloutier MM, Dixon AE, Krishnan JA, et al. Managing asthma in adolescents and adults: 2020 asthma guideline update from the National Asthma Education and Prevention Program. JAMA. 2020;324(22): 2301-2317.
4. Wechsler ME, Colice G, Griffiths JM, et al. SOURCE: a phase 3, multicentre, randomized, double-blind, placebo-controlled, parallel group trial to evaluate the efficacy and safety of tezepelumab in reducing oral corticosteroid used in adults with oral corticosteroid dependent asthma. Respir Res. 2020;21(1):264.