Tezspire® (Tezepelumab-Ekko)

Policy Number: CS2026D00110M
Effective Date: April 1, 2026

Instructions for Use

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Commercial Policy

- Tezspire® (Tezepelumab-Ekko)

Application

This Medical Benefit Drug Policy does not apply to the states listed below; refer to the state-specific policy/guideline, if noted:

State	Policy/Guideline
Arizona	Refer to the state's Medicaid clinical policy
Florida	Refer to the state's Medicaid clinical policy
Indiana	Refer to the state's Medicaid clinical policy
Kansas	Refer to the state's Medicaid clinical policy
North Carolina	None
Ohio	Tezspire® (Tezepelumab-Ekko) (for Ohio Only)
Pennsylvania	Refer to the state's Medicaid clinical policy
Texas	Refer drug specific criteria found within the *Texas Medicaid Provider Procedures Manual*

Coverage Rationale

This policy refers to Tezspire (tezepelumab-ekko) vial and pre-filled syringe for administration by a healthcare professional. Tezspire (tezepelumab-ekko) prefilled pen for self-administration is obtained under the pharmacy benefit.

Severe Asthma

Tezspire, for provider administration, is proven and medically necessary when all of the following criteria is met:

- For **initial therapy**, **all** of the following:
  - Diagnosis of severe asthma; **and**
  - Classification of asthma as uncontrolled or inadequately controlled as defined by at least **one** of the following:
    - Poor symptom control (e.g., ACQ score consistently greater than 1.5 or ACT score consistently less than 20); **or**
    - Two or more bursts of systemic corticosteroids for at least 3 days each in the previous 12 months; **or**
    - Asthma-related emergency treatment (e.g., emergency room visit, hospital admission, or unscheduled physician's office visit for nebulizer or other urgent treatment); **or**
    - Airflow limitation [e.g., after appropriate bronchodilator withhold FEV1 less than 80% predicted (in the face of reduced FEV1/FVC defined as less than the lower limit of normal)]; **or**
    - Patient is currently dependent on maintenance therapy with oral corticosteroids for the treatment of asthma

and

- Used in combination with **one** of the following:
  - One maximally-dosed (appropriately adjusted for age) combination inhaled corticosteroid (ICS)/long-acting beta$_2$ agonist (LABA) product [e.g., Advair/AirDuo Respiclick (fluticasone propionate/salmeterol), Symbicort (budesonide/formoterol), Breo Ellipta (fluticasone furoate/vilanterol)]; **or**
  - Combination therapy including **both** of the following:
    - One maximally-dosed (appropriately adjusted for age) ICS product [e.g., ciclesonide (Alvesco®), mometasone furoate (Asmanex®), beclomethasone dipropionate (QVAR®)]; **and**
    - One additional asthma controller medication [e.g., LABA - olodaterol (Striverdi®) or indacaterol (Arcapta®), leukotriene receptor antagonist – montelukast (Singulair®), theophylline]

  and
- **One** of the following:
  - **Both** of the following:
    - Tezspire will be used to treat eosinophilic asthma; **and**
    - History of failure, contraindication, or intolerance to a 4-month trial of **both** of the following:
      - Anti-interleukin 5 therapy [e.g., Nucala (mepolizumab), Fasenra (benralizumab)]; **and**
      - Anti-interleukin 4 [e.g., Dupixent (dupilumab)]

    or
  - **Both** of the following:
    - Tezspire will be used to treat persistent allergic asthma; **and**
    - History of failure, contraindication, or intolerance to a 4-month trial of Xolair (omalizumab)

    or
  - **Both** of the following:
    - Tezspire will be used to treat oral corticosteroid dependent asthma; **and**
    - History of failure, contraindication, or intolerance to a 4-month trial of Dupixent (duplimab)

    or
  - Patient's asthma is not of the eosinophilic allergic or oral corticosteroid dependent phenotype; **or**
  - Patient is currently on Tezspire

  and
- Patient is not receiving Tezspire in combination with any of the following for treatment of the same indication:
  - Anti-interleukin 5 therapy [e.g., Cinqair (reslizumab), Fasenra (benralizumab), Nucala (mepolizumab)]; **or**
  - Anti-IgE therapy [e.g., Xolair (omalizumab)]; **or**
  - Anti-interleukin 4 therapy [e.g., Dupixent (dupilumab)]

  and
- **One** of the following:
  - Physician attestation that the patient or caregiver is not competent or is physically unable to administer the Tezspire product FDA labeled for self-administration; **or**
  - Patient has documented history of severe hypersensitivity reactions (e.g., anaphylaxis, angioedema, bronchospasm, or hypotension) to Tezspire within the past 6 months and requires administration and direct monitoring by a healthcare professional; **or**
  - Patient is new to therapy with Tezspire and requires initial dose to be directly monitored by a healthcare professional before continued self-administration (Note: Authorization will be for 1 dose)

  and
- Tezspire dosing is in accordance with the United States Food and Drug Administration approved labeling; **and**
- Tezspire is prescribed by a pulmonologist or allergist/immunologist; **and**
- Initial authorization will be for no more than 12 months

- For **continuation of therapy**, **all** of the following:
  - Documentation of a positive clinical response as demonstrated by at least **one** of the following:
    - Reduction in the frequency of exacerbations; **or**
    - Decreased utilization of rescue medications; **or**
    - Increase in percent predicted FEV1 from pretreatment baseline; **or**
    - Reduction in severity or frequency of asthma-related symptoms (e.g., wheezing, shortness of breath, coughing, etc.)

    and
  - Used in combination with an ICS-containing maintenance medication; **and**
  - Patient is not receiving Tezspire in combination with any of the following for treatment of the same indication:
    - Anti-interleukin 5 therapy [e.g., Cinqair (reslizumab), Fasenra (benralizumab), Nucala (mepolizumab)]; **or**
    - Anti-IgE therapy [e.g., Xolair (omalizumab)]; **or**
    - Anti-interleukin 4 therapy [e.g., Dupixent (dupilumab)]

    and

- **One** of the following:
  - Physician attestation that the patient or caregiver is not competent or is physically unable to administer the Tezspire product FDA labeled for self-administration; **or**
  - Patient has documented history of severe hypersensitivity reactions (e.g., anaphylaxis, angioedema, bronchospasm, or hypotension) to Tezspire within the past 6 months and requires administration and direct monitoring by a healthcare professional

  and
- Tezspire dosing is in accordance with the United States Food and Drug Administration approved labeling; **and**
- Reauthorization will be for no more than 12 months

Chronic Rhinosinusitis With Nasal Polyps (CRSwNP)

Tezspire, for provider administration, is proven and medically necessary when all of the following criteria are met:

- For **initial therapy**, **all** of the following:
  - Diagnosis of chronic rhinosinusitis with nasal polyps (CRSwNP) defined by **all** of the following:
    - **Two** or more of the following symptoms for longer than 12 weeks duration:
      - Nasal mucopurulent discharge
      - Nasal obstruction, blockage, or congestion
      - Facial pain, pressure, and/or fullness
      - Reduction or loss of sense of smell

      and
    - **One** of the following findings using nasal endoscopy and/or sinus computed tomography (CT):
      - Purulent mucus or edema in the middle meatus or ethmoid regions; **or**
      - Polyps in the nasal cavity or the middle meatus; **or**
      - Radiographic imaging demonstrating mucosal thickening or partial or complete opacification of paranasal sinuses

      and
    - **One** of the following:
      - Presence of bilateral nasal polyposis; **or**
      - Patient has previously required surgical removal of bilateral nasal polyps

      and
    - **One** of the following:
      - Patient has required prior sinus surgery; **or**
      - Patient has required systemic corticosteroids (e.g., prednisone, methylprednisolone) for CRSwNP in the previous 2 years; **or**
      - Patient has been unable to obtain symptom relief after trial of **two** of the following classes of agents:
        - Nasal saline irrigations
        - Intranasal corticosteroids (e.g., fluticasone, mometasone, triamcinolone)
        - Antileukotriene agents (e.g., montelukast, zafirlukast, zileuton)

    and
  - **One** of the following:
    - History of failure, contraindication, or intolerance to a 4-month trial of **two** of the following:
      - Anti-interleukin 5 therapy [e.g., Nucala (mepolizumab)]
      - Anti-interleukin 4 [e.g., Dupixent (dupilumab)]
      - Anti-IgE therapy [e.g., Xolair (omalizumab)]

      or
    - Patient is currently on Tezspire therapy

    and
  - Patient will receive Tezspire as add-on maintenance therapy in combination with intranasal corticosteroids (e.g., fluticasone, mometasone, triamcinolone); **and**
  - Patient is not receiving Tezspire in combination with **any** of the following for treatment of the same indication:
    - Anti-interleukin 5 therapy [e.g., Cinqair (resilizumab), Fasenra (benralizumab), Nucala (mepolizumab)]
    - Anti-IgE therapy [e.g., Xolair (omalizumab)]
    - Anti-interleukin 4 therapy [e.g., Dupixent (dupilumab)]

    and
  - Dosing is in accordance with the United States Food and Drug Administration approved labeling; **and**
  - Prescribed by an allergist/immunologist/otolaryngologist/pulmonologist; **and**
  - Initial authorization will be for no more than 12 months
- For **continuation of therapy**, **all** of the following:

- Documentation of positive clinical response to Tezspire therapy; **and**
- Patient will continue to receive Tezspire as add-on maintenance therapy in combination with intranasal corticosteroids (e.g., fluticasone, mometasone, triamcinolone); **and**
- Patient is not receiving Tezspire in combination with **any** of the following for treatment of the same indication:
  - Anti-interleukin 5 therapy [e.g., Cinqair (resilizumab), Fasenra (benralizumab), Nucala (mepolizumab)]
  - Anti-IgE therapy [e.g., Xolair (omalizumab)]
  - Anti-interleukin 4 therapy [e.g., Dupixent (dupilumab)]

  and
- Dosing is in accordance with the United States Food and Drug Administration approved labeling; **and**
- Reauthorization will be for no more than 12 months

Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

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

Diagnosis Code	Description
J31.0	Chronic rhinitis
J32.0	Chronic maxillary sinusitis
J32.1	Chronic frontal sinusitis
J32.2	Chronic ethmoidal sinusitis
J32.3	Chronic sphenoidal sinusitis
J32.4	Chronic pansinusitis
J32.8	Other chronic sinusitis
J32.9	Chronic sinusitis, unspecified
J33.0	Polyp of nasal cavity
J33.1	Polypoid sinus degeneration
J33.8	Other polyp of sinus
J33.9	Nasal polyp, unspecified
J45.50	Severe persistent asthma, uncomplicated
J45.51	Severe persistent asthma with (acute) exacerbation
J45.52	Severe persistent asthma with status asthmaticus
J82.83	Eosinophilic asthma

Background

Asthma is a common chronic inflammatory disease of the airways that affects an estimated 24 million adults and children. Although the disease is well controlled with inhaled therapy in most patients, approximately 1.2-2.4 million people have severe asthma (i.e., 5-10% of the asthma population) that is associated with substantial morbidity, mortality, and economic effects. Asthma has been divided into various clinical presentations or phenotypes. Key asthma phenotypes include allergic asthma, eosinophilic asthma, and non-eosinophilic asthma. Eosinophilic asthma is characterized by an increase in the blood and sputum eosinophil (EOS) levels; fractional exhaled nitric oxide (FeNO) also provides an indication of level of eosinophilic inflammation in the lung. In contrast, allergic asthma is characterized by a positive perennial aeroallergen skin test and/or increased levels of serum IgE. In current clinical practice, such phenotypic biomarkers are central to the management of severe, uncontrolled asthma as existing asthma biologic therapies are

targeted at either eosinophilic or allergic asthma.[1] Approximately one-half of patients may present with overlapping or changing phenotypes, and almost 30% may not have a defined inflammatory pathway.[2]

Chronic rhinosinusitis with nasal polyps (CRSwNP) is an inflammatory condition involving the paranasal sinuses and linings of the nasal passages, which persists for 12 weeks or longer, and affects approximately 2-4% of the population. Symptoms include mucopurulent drainage, nasal obstruction, facial pain/pressure/fullness, and decreased sense of smell. CRSwNP cannot be cured in most patients and therapy is intended to reduce symptoms and improve quality of life. Standard treatment includes therapies to minimize inflammation such as intranasal corticosteroids and antileukotriene agents. If intranasal and oral corticosteroids fail to reduce polyp tissue sufficiently and the patient has persistent blockage, sinus surgery or therapy with a biologic recommended.

Tezepelumab is a human monoclonal antibody that acts at the top of the inflammatory cascade by specifically binding TSLP, blocking TSLP from interacting with its receptor. Blocking TSLP with tezepelumab-ekko reduces downstream markers of airway and mucosal inflammation, including blood EOS, immunoglobulin E (IgE), fractional exhaled nitric oxide (FeNO), interleukin 5 (IL-5), and interleukin 13 (IL-13); however, the mechanism of tezepelumab action in asthma and CRSwNP has not been definitively established.[3] Unlike other FDA-approved biologic therapies for severe asthma that target downstream inflammatory pathways and are indicated for specific patient phenotypes, because of its upstream activity early in the inflammatory cascade, Tezepelumab-ekko is suitable for a broad spectrum of severe asthma patients irrespective of asthma phenotype.

Clinical Evidence

Proven

Severe Asthma

Tezepelumab is indicated for the add-on maintenance treatment of adult and pediatric patients aged 12 years and older with severe asthma.[4]

The efficacy of tezepelumab was established in two randomized, double-blind, placebo-controlled studies in 1,609 patients 12 years of age and older with severe asthma. PATHWAY was a 52-week dose-ranging study in which patients received tezepelumab-ekko 70 mg every 4 weeks, Tezspire 210 mg every 4 weeks, tezepelumab-ekko 280 mg every 2 weeks, or placebo. NAVIGATOR was a 52-week study in which patients received Tezepelumab 210 mg every 4 weeks or placebo. The primary endpoint in both studies was the rate of clinically significant asthma exacerbations measured over 52 weeks. Asthma exacerbations were 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. In PATHWAY, the annualized rate of asthma exacerbations was 0.20 with tezepelumab vs. 0.72 with placebo (rate ratio 0.29, 95% CI: 0.16, 0.51). In NAVIGATOR, the annualized rate of asthma exacerbations was 0.93 with tezepelumab vs. 2.10 with placebo (rate ratio 0.44, 95% CI: 0.37, 0.53). In NAVIGATOR, patients receiving tezepelumab experienced fewer exacerbations than those receiving placebo regardless of baseline levels of blood eosinophils or fractional exhaled nitric oxide (FeNO). Similar results were seen in PATHWAY.

Tezepelumab was also evaluated in a randomized, double-blind, placebo-controlled clinical study in 150 adult patients with severe asthma requiring treatment with daily oral corticosteroids (OCS). Patients received tezepelumab 210 mg every 4 weeks or placebo. The primary endpoint was categorized percent reduction from baseline of the final OCS dose at week 48 (≥ 90% reduction, ≥ 75% to < 90% reduction, ≥ 50% to < 75% reduction, > 0% to < 50% reduction, and no change or no decrease in OCS), while maintaining asthma control. Tezspire did not demonstrate a statistically significant reduction in maintenance OCS dose vs. placebo (cumulative odds ratio 1.28, 95% CI: 0.69, 2.35).

Chronic Rhinosinusitis With Nasal Polyps

Tezepelumab is indicated for the add-on maintenance treatment of adult and pediatric patients aged 12 years and older with inadequately controlled chronic rhinosinusitis with nasal polyps (CRSwNP).

The efficacy of tezepelumab for add-on maintenance treatment of inadequately controlled chronic rhinosinusitis with nasal polyps (CRSwNP) was established in the WAYPOINT pivotal trial. This was a randomized, double-blind, parallel group, multicenter, placebo-controlled trial (NCT04851964) with a total duration of 52 weeks. The trial included 408 participants aged 18 years and older on standard of care treatment for CRSwNP. Inclusion criteria required that patients were symptomatic with CRSwNP despite treatment with nasal corticosteroids, and who had systemic corticosteroids within the past 12 months and/or any history of sino-nasal surgery, or with contraindications and/or intolerance to either. Patients received tezepelumab or placebo every 4 weeks for 52 weeks in addition to nasal corticosteroid treatment for CRSwNP.

The co-primary efficacy endpoints were change from baseline in total nasal polyp score (NPS) and change from baseline in bi-weekly mean nasal congestion score (NCS) evaluated at Week 52. The change from baseline in total NPS was significantly greater with tezepelumab than with placebo [least-squares mean difference, −2.08; 95% confidence interval (CI), −2.40 to −1.76; p < 0.001]. The change from baseline in the NCS at week 52 was also significantly greater with tezepelumab than with placebo (least-squares mean difference, −1.04; 95% CI, −1.21 to −0.87; p < 0.001). Key secondary endpoints included time to surgery decision and/or systemic corticosteroid use for nasal polyps, change from baseline in loss of smell, and change from baseline in Lund-Mackay (LMK) sinus CT scan score at Week 52. Tezepelumab significantly reduced the proportion of patients with need for sino-nasal surgery or systemic corticosteroids by 92% compared to placebo over 52 weeks (Hazard Ratio: 0.08; 95% CI: 0.03, 0.17). At week 52, significant improvements in the loss-of-smell score were observed with tezepelumab as compared with placebo (least-squares mean difference, −1.01; 95% CI, −1.18 to −0.83; p < 0.001). Significant improvements in the SNOT-22 total score were also observed with tezepelumab as compared with placebo (least-squares mean difference, −27.44; 95% CI, −32.51 to −22.37), Lund–Mackay score (−5.70; 95% CI, −6.37 to −5.03), and total symptom score (−6.96; 95% CI, −8.09 to −5.83) (p < 0.001 for all scores). A decision to treat with nasal-polyp surgery or to use systemic glucocorticoids was also reported in significantly fewer patients in the tezepelumab group (5.7%) than in the placebo group (31.4%) (hazard ratio, 0.08; 95% CI, 0.03 to 0.16; p < 0.001).

Professional Societies

Global Initiative for Asthma

The Global Initiative for Asthma (GINA, 2023) defines uncontrolled, difficult-to-treat and severe asthma as follows:[1]

- Uncontrolled asthma is asthma with poor symptom control (frequent symptoms or reliever use, activity limited by asthma, night waking due to asthma) and/or frequent exacerbations (≥ 2/year) requiring OCS, or serious exacerbations (≥ 1/year) requiring hospitalization.
- Difficult-to-treat asthma is asthma that is uncontrolled despite prescribing of medium- or high-dose ICS with a second controller (usually a LABA) or maintenance OCS, or that requires high-dose treatment to maintain good symptom control and reduce the risk of exacerbations.
- Severe asthma is asthma that is uncontrolled despite adherence with maximal optimized high-dose ICS-LABA treatment and management of contributory factors, or that worsens when high-dose treatment is decreased. Asthma is not classified as severe if it markedly improves when contributory factors such as inhaler technique and adherence are addressed.

The Global Initiative for Asthma (GINA, 2023) recommends add-on biologic therapy for treatment of adults, adolescents, and children with uncontrolled severe asthma despite optimized maximal therapy as follows:

- Add-on anti-immunoglobulin E (anti-IgE) treatment (omalizumab) for patients aged ≥ 6 years with severe allergic asthma (Evidence A).
- Add-on anti-interleukin 5/5R treatment (subcutaneous mepolizumab for patients aged ≥ 6 years; intravenous reslizumab for ages ≥ 18 years; subcutaneous benralizumab for ages ≥ 12 years) with severe eosinophilic asthma (Evidence A).
- Add-on anti-interleukin-4R α treatment (subcutaneous dupilumab) for patients aged ≥ 6 years with severe eosinophilic/Type 2 asthma, or for adults or adolescents requiring treatment with maintenance OCS (Evidence A).
- Add-on anti-thymic stromal lymphopoietin (anti-TSLP) treatment (subcutaneous tezepelumab for patients aged ≥ 12 years with severe asthma) (Evidence A).

The Global Initiative for Asthma (GINA, 2023) recommends that low dose oral corticosteroids (≤ 7.5 mg/day prednisone equivalent) should only be considered as last resort in adult patients with severe asthma with poor symptom control and/or frequent exacerbations despite good inhaler technique and adherence with Step 5 treatment, and after exclusion of other contributory factors and other add-on treatments including biologics where available and affordable (Evidence D). Oral corticosteroids are often associated with substantial side effects (Evidence A).

Institute for Clinical and Economic Review (ICER)

On November 4, 2021, the Institute for Clinical and Economic Review (ICER) released a clinical report entitled, "Tezepelumab for Severe Asthma." ICER recommendations are as follows: [5]

- ICER rates the net health benefit of tezepelumab added to standard-of-care therapy without biologics, compared with standard-of-care therapy alone in adults and adolescents with severe, uncontrolled asthma as "Comparable or Better" (C ++).
- ICER judges the current body of evidence tezepelumab compared with dupilumab in patients with eosinophilic asthma as "Insufficient" (I). In the subgroup of patients with eosinophilic asthma, reductions in AAER and (small) improvements in daily symptoms and quality of life seem similar to those seen with dupilumab. Dupilumab has

substantially more evidence on long-term safety.
- ICER judges the current body of evidence for tezepelumab compared with omalizumab in patients with allergic asthma as "insufficient" (I).
- ICER rates the treatment of patients with steroid-dependent asthma as "Comparable or Inferior" (C-) to treatment with dupilumab.

European Respiratory Society (ERS)/American Thoracic Society (ATS)

The first European Respiratory Society (ERS)/American Thoracic Society (ATS) guidelines on severe asthma were published in 2014. Severe asthma was defined as that which requires treatment with high-dose ICSs plus a second controller (or systemic corticosteroids) to prevent progression to uncontrolled disease status or continuing uncontrolled disease status despite this therapy.[3] Emphasis was placed on the necessity to confirm the diagnosis of asthma and exclude other conditions that may mimic asthma. In addition, the guidelines recognized that severe asthma is a heterogeneous condition consisting of phenotypes such as severe eosinophilic asthma, and specific recommendations were made on the use of sputum eosinophil count and exhaled nitric oxide fraction (F_{ENO}) to guide therapy. Recommendations were also made for the use of methotrexate, macrolide antibiotics, antifungal agents, bronchial thermoplasty and the anti-IgE antibody omalizumab in severe asthma.

In 2020, the European Respiratory Society (ERS)/American Thoracic Society (ATS) published updated guidelines for the management of asthma.[23] Six specific and important questions were formulated using the PICO (patient population, intervention, comparison and outcome) format. The GRADE (grading of recommendations, assessment, development and evaluation) approach was used to assess the strength of evidence and develop recommendations. These recommendations are summarized below:
- An anti-interleukin (IL)-5 and anti-IL-5 receptor α for severe uncontrolled adult eosinophilic asthma phenotypes.
- A blood eosinophil cut-point ≥ 150 μL^{-1} to guide anti-IL-5 initiation in adult patients with severe asthma.
- Specific eosinophil (≥ 260 μL^{-1}) and exhaled nitric oxide fraction (≥ 19.5 ppb) cut-offs to identify adolescents or adults with the greatest likelihood of response to anti-IgE therapy.
- Inhaled tiotropium for adolescents and adults with severe uncontrolled asthma despite Global Initiative for Asthma (GINA) step 4-5 or National Asthma Education and Prevention Program (NAEPP) step 5 therapies.
- A trial of chronic macrolide therapy to reduce asthma exacerbations in persistently symptomatic or uncontrolled patients on GINA step 5 or NAEPP step 5 therapies, irrespective of asthma phenotype.
- Anti-IL-4/13 for adult patients with severe eosinophilic asthma and for those with severe corticosteroid-dependent asthma regardless of blood eosinophil levels.

U.S. Food and Drug Administration (FDA)

This section is to be used for informational purposes only. FDA approval alone is not a basis for coverage.

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

References

1. Global Initiative for Asthma. Global Strategy for Asthma Management and Prevention, 2023. Available at: http://www.ginasthma.org. Accessed September 9, 2025.
2. Tran TN, Zeiger RS, Peters SP, et al. Overlap of atopic, eosinophilic, and TH2-high asthma phenotypes in a general population with current asthma. Ann Allergy Asthma Immunol. 2016;116(1):37-42. doi:10.1016/j.anai.2015.10.027.
3. Corren J, Ziegler SF. TSLP: from allergy to cancer. Nat Immunol. 2019;20(12):1603-1609. doi:10.1038/s41590-019-0524-9.
4. Tezspire® [package insert]. Thousand Oakes, CA: Amgen Inc.; October 2025.
5. Institute for Clinical and Economic Review (ICER). Tezepelumab for Severe Asthma. November 4, 2021. Available at: ICER | Working Towards Fair Pricing, Fair Access, & Future Innovation. Accessed September 9, 2024.
6. Holguin F, Cardet JC, Chung KF, et al. Management of severe asthma: a European Respiratory Society/American Thoracic Society guideline. Eur Respir J. 2020 Jan 2;55(1):1900588. doi: 10.1183/13993003.00588-2019. PMID: 31558662.

7. Buchheit, K. Chronic rhinosinusitis with nasal polyposis: Management and prognosis. UpToDate. Waltham, MA: UpToDate Inc. https://www.uptodate.com. Accessed November 5, 2025.

Policy History/Revision Information

Date	Summary of Changes
04/01/2026	**Template Update** • Removed content/language pertaining to the state of Louisiana **Supporting Information** • Archived previous policy version CS2026D00110L

Instructions for Use

This Medical Benefit Drug Policy provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the federal, state or contractual requirements for benefit plan coverage must be referenced as the terms of the federal, state or contractual requirements for benefit plan coverage may differ from the standard benefit plan. In the event of a conflict, the federal, state or contractual requirements for benefit plan coverage govern. Before using this policy, check the federal, state or contractual requirements for benefit plan coverage. UnitedHealthcare reserves the right to modify its Policies and Guidelines as necessary. This Medical Benefit Drug Policy is provided for informational purposes. It does not constitute medical advice.

UnitedHealthcare may also use tools developed by third parties, such as the InterQual® criteria, to assist us in administering health benefits. The UnitedHealthcare Medical Benefit Drug Policies are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.