blue california
Promise Health Plan

tezepelumab-ekko (Tezspire) prefilled syringe and vial

Medical Benefit Drug Policy

Place of Service
Home Infusion
Infusion Center Administration
Office Administration
Outpatient Facility Infusion Administration

Condition(s) listed in policy *(see coverage criteria for details)*

- Severe Asthma

Any condition not listed in this policy requires a review to confirm it is medically necessary. For conditions that have not been approved for intended use by the Food and Drug Administration (i.e., off-label use), the criteria outlined in the California Code of Regulations (CCR), Title 22, Section 51303 and 51313 must be met.

Special Instructions and Pertinent Information

Provider must submit documentation (such as office chart notes, lab results or other clinical information) to ensure the member has met all medical necessity requirements.

The member's specific benefit may impact drug coverage. Other utilization management processes, and/or legal restrictions may take precedence over the application of this clinical criteria.

Coverage Criteria
The following condition(s) require Prior Authorization/Preservice.

Severe Asthma
Meets medical necessity if all the following are met:
Initial:
1. Age is consistent with the FDA approved indication (12 years of age and older)
2. Asthma symptoms remain uncontrolled despite 3 months of treatment with a high-dose inhaled corticosteroid in combination with long-acting beta agonist [LABA] or leukotriene receptor antagonists [LTRA]
3. Not used in combination with another biologic medication indicated for asthma treatment
4. Meets ONE of the following within the past year:
   a. One or more acute asthma attacks requiring emergency care (hospital emergency dept visit)
   b. One or more acute inpatient visits where asthma was the principal diagnosis
   c. Use of chronic systemic steroids due to severe asthma OR two or more acute asthma exacerbations requiring oral systemic steroids

Reauthorization:

1. Not being used in combination with another biologic medication indicated for asthma treatment
2. Asthma symptoms have improved and/or controlled while on Tezspire

Covered Doses:
Up to 210 mg given subcutaneously once every 4 weeks

Coverage Period:
Initial: 6 months
Reauthorization: Yearly

ICD-10:
J45.40, J45.41, J45.42, J45.50, J45.51, J45.52

References

1. AHFS. Available by subscription at http://www.lexi.com
   DrugDex. Available by subscription at
   http://www.micromedexsolutions.com/home/dispatch
2. Tezspire (tezepelumab) Prescribing Information. Amgen, Inc; Thousand Oaks, CA: 10/2025
3. Global Initiative for Asthma. Global Strategy for Asthma Management and Prevention (2025 Update). Available from: www.ginasthma.org.

Review History

Date of Last Annual Review: 4Q2025
Changes from previous policy version:

- Removed specialist requirement for severe asthma (Rationale: Prescribing patterns consistent with expected specialists)

Blue Shield of California Medication Policy to Determine Medical Necessity
Reviewed by P&T Committee