Tezspire (tezepelumab-ekko) Prior Authorization with Quantity Limit Program Summary

This program applies to MN Medicaid.

The BCBS MN Step Therapy Supplement also applies to this program for Medicaid.

POLICY REVIEW CYCLE

Effective Date
04-01-2024

Date of Origin
07-01-2023

FDA APPROVED INDICATIONS AND DOSAGE

Agent(s)	FDA Indication(s)	Notes	Ref#
Tezspire® (tezepelumab-ekko) Subcutaneous injection	Add-on maintenance treatment of adult and pediatric patients 12 years and older with severe asthma Limitation of use: • Not for the relief of acute bronchospasm or status asthmaticus		1

See package insert for FDA prescribing information: https://dailymed.nlm.nih.gov/dailymed/index.cfm

CLINICAL RATIONALE

Asthma	Asthma is a chronic inflammatory disorder of the airways.(2,3) It is characterized by variable and recurring clinical symptoms, airflow obstruction, bronchial hyperresponsiveness, and underlying inflammation.(2) Symptoms of asthma include wheezing, coughing, recurrent difficulty breathing, shortness of breath, and chest tightness. Generally, these symptoms will occur or worsen with exposure to allergens and irritants, infections, exercise, changes in weather, stress, or menstrual cycles. Guidelines recommend the use of detailed medical history, physical examination, and spirometry to make a diagnosis of asthma.(2,3) The Global Initiative for Asthma (GINA) guidelines recommend a stepwise approach for managing asthma. Long-term goals for asthma management are to achieve good control of symptoms, maintain normal activity level, and to minimize the future risk of exacerbations, fixed airflow limitation, and side-effects.(3) IgE is the antibody responsible for activation of allergic reactions and is important to the pathogenesis of allergic asthma and the development and persistence of inflammation. GINA guidelines define moderate asthma as that which is well controlled with Step 3 or Step 4 treatment (e.g., low- or medium-dose inhaled corticosteroids [ICS] in combination with a long-acting beta agonist [LABA] in either treatment track). Severe asthma is defined as asthma that remains uncontrolled despite optimized treatment with high-dose ICS-LABA, or that requires high-dose ICS-LABA to prevent it from becoming uncontrolled. Severe asthma must be distinguished from asthma that is difficult to treat due to inadequate or inappropriate treatment, or persistent problems with adherence or comorbidities such as chronic rhinosinusitis or obesity, as they need very different treatment compared with if asthma is relatively refractory to high-dose ICS-LABA or even oral corticosteroids (OCS). Early initiation of low dose ICS in patients with asthma has led to greater improvement in lung function than initiation of ICS after symptoms have been present for more than 2 to 4 years. The 2023 GINA guidelines recommend every adult and adolescent with asthma should receive ICS-

containing controller medication to reduce the risk of serious exacerbation, even in patients with infrequent symptoms.(3)

2023 GINA STEP recommendations for adults and adolescents (12 years of age and over) are intended to reduce the risk of serious exacerbations and are broken into two tracks based on reliever therapy.

Track 1 is the preferred approach recommended by GINA, because using low dose ICS-formoterol as reliever reduces the risk of exacerbations compared with regimens with short-acting β2-agonist (SABA) as reliever, and is a simpler regimen. Note ICS-formoterol should not be used as the reliever by patients taking any other (non-formoterol) ICS-LABA or ICS-LAMA:(3)

- Step 1:
  - As-needed low dose ICS-formoterol
- Step 2:
  - As-needed low dose ICS-formoterol
- Step 3: address and treat modifiable risk factors (e.g., adherence, technique) before considering step up
  - Maintenance: low dose ICS-formoterol
  - Reliever: as-needed low dose ICS-formoterol
- Step 4:
  - Maintenance: medium dose ICS-formoterol
  - Reliever: as-needed low dose ICS-formoterol
- Step 5: patients with uncontrolled symptoms and/or exacerbations despite Step 4 treatment should be assessed for contributory factors, have their treatment optimized, and be referred for expert assessment including severe asthma phenotype, and potential add on treatment
  - Maintenance: consider high dose ICS-formoterol
  - Reliever: as-needed low dose ICS-formoterol
  - Add-on LAMA for patients greater than or equal to 18 years (greater than or equal to 6 years for tiotropium) in separate or combination inhalers
  - Refer for phenotypic assessment +/- biologic therapy
    - Add-on anti-IgE for severe allergic asthma
      - SC omalizumab in patients greater than or equal to 6 years
    - Add-on anti-interleukin (IL)5 or anti-IL5R or anti-IL4R for severe eosinophilic/Type 2 asthma
      - Anti-IL5: SC mepolizumab for patients greater than or equal to 6 years OR IV reslizumab for patients greater than or equal to 18 years of age
      - Anti-IL5R: SC benralizumab for patients greater than or equal to 12 years
      - Anti-IL4R: SC dupilumab for patients greater than or equal to 6 years
    - Add-on anti-thymic stromal lymphopoietin (TSLP) for severe asthma
      - SC tezepelumab for patients greater than or equal to 12 years
  - Add-on azithromycin three days/week reduces exacerbations, but increases antibiotic resistance
  - Maintenance oral corticosteroids (OCS) should be used only as last resort, because short-term and long-term systemic side-effects are common and serious

Track 2 is an alternative approach if Track 1 is not possible or is not preferred by a patient with no exacerbations on their current therapy. Before considering a regimen with SABA reliever, the clinician should consider whether the patient is likely to be

	adherent with their controller therapy; if not, they will be exposed to the higher risk of exacerbations with SABA-only treatment:(3)
	
	• Step 1:
	  ○ Take ICS whenever SABA taken
	  ○ Reliever: as-needed ICS-SABA or as needed SABA
	• Step 2:
	  ○ Preferred maintenance: low dose ICS
	  ○ Preferred reliever: as-needed ICS-SABA or as-needed SABA
	  ○ Alternative options with limited indications, or less evidence for efficacy and/or safety:
	  ▪ Low dose ICS whenever SABA taken
	  ▪ Daily LTRA. These are less effective than daily ICS, particularly for preventing exacerbations and there is a US FDA boxed warning about the risk of serious mental health effects with montelukast
	  ▪ Daily low-dose ICS-LABA as initial therapy leads to faster improvement in symptoms and FEV1 than ICS alone but is costlier, and the reduction in exacerbations compared with SABA is similar to that with ICS
	  ▪ For adults with rhinitis who are allergic to house dust mite and have FEV1 > 70% predicted, consider adding sublingual immunotherapy (SLIT)
	• Step 3: address and treat modifiable risk factors (e.g., adherence, technique) before considering step up
	  ○ Preferred maintenance: low dose ICS-LABA
	  ○ Preferred reliever: as-needed ICS-SABA or as-needed SABA
	  ○ Alternative options:
	  ▪ Medium dose ICS
	  ▪ Low-dose ICS plus LTRA but review US FDA boxed warning
	  ▪ For adults with rhinitis who are allergic to house dust mite and have FEV1 > 70% predicted, consider adding SLIT
	• Step 4:
	  ○ Preferred maintenance: medium/high dose ICS-LABA
	  ○ Preferred reliever: as-needed ICS-SABA or as-needed SABA
	  ○ Alternative options:
	  ▪ Add-on LAMA for patients greater than or equal to 18 years (greater than or equal to 6 years for tiotropium my mist inhaler)
	  ▪ Before considering add-on LAMA for patients with exacerbations, increase ICS dose to at least medium
	  ▪ For adults with rhinitis who are allergic to house dust mite and have FEV1 > 70% predicted, consider adding sublingual immunotherapy (SLIT)
	• Step 5: patients with uncontrolled symptoms and/or exacerbations despite Step 4 treatment should be assessed for contributory factors, have their treatment optimized, and be referred for expert assessment including severe asthma phenotype, and potential add on treatment
	  ○ Maintenance: medium/high dose ICS-LABA
	  ○ Reliever: as-needed ICS-SABA or as-needed SABA
	  ○ Add-on LAMA for patients greater than or equal to 18 years (greater than or equal to 6 years for tiotropium) in separate or combination inhalers
	  ○ Refer for phenotypic assessment +/- biologic therapy
	  ▪ Add-on anti-IgE for severe allergic asthma
	  • SC omalizumab in patients greater than or equal to 6 years
	  ▪ Add-on anti-interleukin (IL)5 or anti-IL5R or anti-IL4R for severe eosinophilic/Type 2 asthma
	  • Anti-IL5: SC mepolizumab for patients greater than or equal to 6 years OR IV reslizumab for patients greater than or equal to 18 years of age

	• Anti-IL5R: SC benralizumab for patients greater than or equal to 12 years • Anti-IL4R: SC dupilumab for patients greater than or equal to 6 years ▪ Add-on anti-thymic stromal lymphopoietin (TSLP) for severe asthma • SC tezepelumab for patients greater than or equal to 12 years o Add-on azithromycin three days/week reduces exacerbations, but increases antibiotic resistance o Maintenance OCS should only be used as last resort, because short-term and long-term systemic side-effects are common and serious 2023 GINA STEP recommendations for children (6 to 11 years of age) are intended to reduce the risk of serious exacerbations:(3) • Step 1: o Low dose ICS taken whenever SABA taken o Reliever: as needed SABA • Step 2: o Preferred: daily low dose ICS o Preferred reliever: as needed SABA o Alternative options: ▪ Low-dose ICS whenever SABA is taken using separate inhalers ▪ Daily LTRA are less effective for exacerbation reduction. Advise parents about US FDA warning on montelukast • Step 3: after checking inhaler technique and adherence, and treating modifiable risk factors (any of the following): o Medium-dose ICS maintenance plus as-needed SABA o Low-dose ICS-LABA maintenance plus as-needed SABA o Maintenance and reliever therapy (MART) with a very low dose of budesonide-formoterol DPI • Step 4: Individual children's responses vary, so each of the Step 3 options may be tried before considering a step-up to Step 4. Refer for expert advice o Preferred: medium dose ICS-LABA plus as-needed SABA o Preferred: low dose ICS-formoterol MART plus as-needed low-dose ICS-formoterol o Alternative options: ▪ Add-on tiotropium ▪ Add-on LTRA • Step 5: o Refer for phenotypic assessment with or without higher dose ICS-LABA o Reliever: as needed SABA (or ICS-formoterol reliever for MART) o Add on therapy with anti-IgE or anti-IL4R, anti-IL5 o As a last resort consider add on low dose OCS but consider side effects **Severe Asthma Phenotype and Eosinophilic Asthma Subphenotype** Roughly 3% to 10% of adults with asthma have severe asthma as defined by the GINA 2023 guidelines.(3) The European Respiratory Society (ERS)/American Thoracic Society (ATS) guidelines (2014; updated 2020) and the National Asthma Education and Prevention Program Coordinating Committee Expert Panel Working Group mirror the GINA definition of severe asthma, and defined uncontrolled asthma for adult and pediatric patients 5 years of age and over:(2,4) • Frequent severe exacerbations (i.e., two or more bursts of systemic corticosteroids within the past 12 months) • Serious exacerbations (i.e., at least one hospitalization, intensive care unit stay, or mechanical ventilation in the past 12 months) • Airflow limitation (i.e., FEV1 less than 80% predicted)

	• Asthma that worsens upon tapering of high-dose ICS or systemic corticosteroids A specialist, preferably in a multidisciplinary severe asthma clinic (if available) performs further assessment, which includes the patient's inflammatory phenotype (i.e., Type 2 or non-Type 2).(3) Type 2 inflammation is characterized by the presence of cytokines such as interleukin (IL)-4, IL-5, and IL-13, which are often produced by the adaptive immune system on recognition of allergens. It is also characterized by eosinophilia or increased fraction of exhaled nitric oxide (FeNO) and may be accompanied by atopy. In many patients with asthma, Type 2 inflammation rapidly improves when ICS are taken regularly and correctly; this is classified as mild or moderate asthma. In severe asthma, Type 2 inflammation may be relatively refractory to high dose ICS. Type 2 inflammation is considered refractory if any of the following are found while the patient is taking high dose ICS or daily OCS:(3) • Blood eosinophils greater than or equal to 150 cells/microliter • FeNO greater than or equal to 20 ppb • Sputum eosinophils greater than or equal to 2% • Asthma is clinically allergen-driven Biologic agents should be considered as add-on therapy for patients with refractory Type 2 inflammation with exacerbations or poor symptom control despite taking at least high dose ICS/LABA, and who have allergic or eosinophilic biomarkers or need maintenance OCS.(3) 2023 GINA recommends the biologics below based on patient eligibility factors: • Anti-IgE (omalizumab): o Sensitization on skin prick testing or specific IgE o Total serum IgE and weight within dosage range o Exacerbations in the last year • Anti-IL5/Anti-IL5R (benralizumab, mepolizumab, reslizumab): o Exacerbations in the last year o Blood eosinophils greater than or equal to 150 cells/microliter (for benralizumab and mepolizumab) or greater than or equal to 300 cells/microliter (for reslizumab) • Anti-IL4R (dupilumab): o Exacerbations in the last year o Blood eosinophil greater than or equal to 150 cells/microliter but less than or equal to 1500 cells/microliter, or FeNO greater than or equal to 25 ppb, or taking maintenance OCS • Anti-TSLP (tezepelumab): o Exacerbations in the last year Patient response should be evaluated 4 months after initiating therapy and follow up should occur every 3 to 6 months thereafter. 2023 GINA recommends the following step-down therapy process in patients responding well to targeted biologic therapy:(3) Reevaluate the need for each asthma medication every 3 to 6 months, but inhaled therapy should not be completely stopped Oral treatments: gradually decreased starting with OCS due to significant adverse effects. Inhaled treatments: consider reducing ICS dose after 3 to 6 months, but do not completely stop inhaled therapy. Continue at least medium dose ICS and remind patients of the importance of continued inhaled controller therapy

	Biologic treatments: trial withdrawal after 12 months of treatment and only if patient's asthma remains well controlled on medium dose ICS, and for allergic asthma, there is no further exposure to a previous allergic trigger
Efficacy	The efficacy of Tezspire was evaluated in two randomized, double-blind, parallel group, placebo-controlled clinical trials (PATHWAY [NCT02054130] and NAVIGATOR [NCT03347279]) of 52 weeks duration. The two trials enrolled a total of 1609 patients 12 years of age and older with severe asthma.(1) PATHWAY was a 52-week dose-ranging exacerbation trial that enrolled 550 adult patients with severe asthma who received treatment with tezepelumab-ekko 70 mg subcutaneously every 4 weeks, Tezspire 210 mg subcutaneously every 4 weeks, tezepelumab-ekko 280 mg subcutaneously every 2 weeks, or placebo subcutaneously. Patients were required to have a history of 2 or more asthma exacerbations requiring oral or injectable corticosteroid treatment or 1 asthma exacerbation resulting in hospitalization in the past 12 months.(1) NAVIGATOR was a 52-week exacerbation trial that enrolled 1061 patients (adult and pediatric patients 12 years of age and older) with severe asthma who received treatment with Tezspire 210 mg subcutaneously every 4 weeks or placebo subcutaneously every 4 weeks. Patients were required to have a history of 2 or more asthma exacerbations requiring oral or injectable corticosteroid treatment or resulting in hospitalization in the past 12 months.(1) In both PATHWAY and NAVIGATOR, patients were required to have an Asthma Control Questionnaire 6 (ACQ-6) score of 1.5 or more at screening and reduced lung function at baseline [pre-bronchodilator forced expiratory volume in 1 second (FEV1) below 80% predicted in adults, and below 90% predicted in adolescents]. Patients were required to have been on regular treatment with medium or high-dose inhaled corticosteroids (ICS) and at least one additional asthma controller, with or without oral corticosteroids (OCS). Patients continued background asthma therapy throughout the duration of the trials. In both trials, patients were enrolled without requiring a minimum baseline level of blood eosinophils or FeNO.(1) The primary endpoint for PATHWAY and NAVIGATOR was the rate of clinically significant asthma exacerbations measured over 52 weeks. Clinically significant 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 both PATHWAY and NAVIGATOR, patients receiving Tezspire had significant reductions in the annualized rate of asthma exacerbations compared to placebo. There were also fewer exacerbations requiring emergency room visits and/or hospitalization in patients treated with Tezspire compared with placebo. In NAVIGATOR, patients receiving Tezspire experienced fewer exacerbations than those receiving placebo regardless of baseline levels of blood eosinophils or FeNO and similar results were seen in PATHWAY. The time to first exacerbation was longer for the patients receiving Tezspire compared with placebo in NAVIGATOR and similar findings were seen in PATHWAY. Change from baseline in FEV1 was assessed as a secondary endpoint in PATHWAY and NAVIGATOR. Compared with placebo, Tezspire provided clinically meaningful improvements in the mean change from baseline in FEV1 in both trials. In NAVIGATOR, improvement in FEV1 was seen as early as 2 weeks after initiation of treatment and was sustained through week 52.(1) Changes from baseline in Asthma Control Questionnaire 6 (ACQ-6) and Standardized Asthma Quality of Life Questionnaire for ages 12 and older [AQLQ(S)+12] were also assessed as secondary endpoints in PATHWAY and NAVIGATOR. In both trials, more patients treated with Tezspire compared to placebo had a clinically meaningful improvement in ACQ-6 and AQLQ(S)+12. Clinically meaningful improvement (responder rate) for both measures was defined as improvement in score of 0.5 or more at end of trial. In NAVIGATOR, the ACQ-6 responder rate for Tezspire was 86% compared with 77% for placebo (OR=1.99; 95% CI 1.43, 2.76) and the AQLQ(S)+12

	responder rate for Tezspire was 78% compared with 72% for placebo (OR=1.36; 95% CI 1.02, 1.82). Similar findings were seen in PATHWAY.(1) In an additional randomized, double-blind, parallel group, placebo-controlled clinical trial, the effect of Tezspire (210 mg subcutaneously every 4 weeks) on reducing the use of maintenance OCS was evaluated. The trial enrolled 150 adult patients with severe asthma who required treatment with daily OCS (7.5 mg to 30 mg per day) in addition to regular use of high-dose ICS and a long-acting beta-agonist with or without additional controller(s). The primary endpoint was categorized percent reduction from baseline of the final OCS dose at Week 48 (greater than or equal to 90% reduction, greater than or equal to 75% to less than 90% reduction, greater than or equal to 50% to less than 75% reduction, greater than 0% to less than 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 compared with placebo (cumulative OR=1.28; 95% CI 0.69, 2.35).(1)
Safety	Tezepelumab-ekko is contraindicated in patients who have a known hypersensitivity to Tezepelumab-ekko or any of its excipients.(1)

REFERENCES

Number	Reference
1	Tezspire prescribing information. Amgen Inc. May 2023.
2	International European Respiratory Society (ERS)/American Thoracic Society (ATS) Guidelines on Management of Severe Asthma. Eur Resp J. 2020;55:1900588. Available at https://erj.ersjournals.com/content/55/1/1900588.
3	Global Initiative for Asthma (GINA). Global Strategy For Asthma Management and Prevention. 2023. Available at www.ginasthma.org.www.ginasthma.org.
4	National Asthma Education and Prevention Program Coordinating Committee Expert Panel Working Group. 2020 Focused updates to the asthma management guidelines. National Heart, Lung, and Blood Institute, 2007. Available at: https://www.nhlbi.nih.gov/health-topics/all-publications-and-resources/2020-focused-updates-asthma-management-guidelines

POLICY AGENT SUMMARY PRIOR AUTHORIZATION

Target Brand Agent(s)	Target Generic Agent(s)	Strength	Targeted MSC	Available MSC	Final Age Limit	Preferred Status
Tezspire	tezepelumab-ekko subcutaneous soln auto-inj	210 MG/1.91ML	M ; N ; O ; Y	N		

POLICY AGENT SUMMARY QUANTITY LIMIT

Target Brand Agent Name(s)	Target Generic Agent Name(s)	Strength	QL Amount	Dose Form	Day Supply	Duration	Addtl QL Info	Allowed Exceptions	Targeted NDCs When Exclusions Exist
Tezspire	tezepelumab-ekko subcutaneous soln auto-inj	210 MG/1.91 ML	1	Pen	28	DAYS			

CLIENT SUMMARY – PRIOR AUTHORIZATION

Target Brand Agent Name(s)	Target Generic Agent Name(s)	Strength	Client Formulary
Tezspire	tezepelumab-ekko subcutaneous soln auto-inj	210 MG/1.91ML	Medicaid

CLIENT SUMMARY – QUANTITY LIMITS

Target Brand Agent Name(s)	Target Generic Agent Name(s)	Strength	Client Formulary
Tezspire	tezepelumab-ekko subcutaneous soln auto-inj	210 MG/1.91ML	Medicaid

PRIOR AUTHORIZATION CLINICAL CRITERIA FOR APPROVAL

Module	Clinical Criteria for Approval

Initial Evaluation

Target Agent(s) will be approved when ALL of the following are met:

1. ONE of the following:
   A. The requested agent is eligible for continuation of therapy AND ONE of the following:

Agents Eligible for Continuation of Therapy
All target agents are eligible for continuation of therapy

      1. Information has been provided that indicates the patient has been treated with the requested agent (starting on samples is not approvable) within the past 90 days **OR**
      2. The prescriber states the patient has been treated with the requested agent (starting on samples is not approvable) within the past 90 days AND is at risk if therapy is changed **OR**

   B. BOTH of the following:
      1. The patient has a diagnosis of severe asthma **AND**
      2. The patient has a history of uncontrolled asthma while on asthma control therapy as demonstrated by ONE of the following:
         A. Frequent severe asthma exacerbations requiring two or more courses of systemic corticosteroids (steroid burst) within the past 12 months **OR**
         B. Serious asthma exacerbations requiring hospitalization, mechanical ventilation, or visit to the emergency room or urgent care within the past 12 months **OR**
         C. Controlled asthma that worsens when the doses of inhaled and/or systemic corticosteroids are tapered **OR**
         D. The patient has baseline (prior to therapy with the requested agent) Forced Expiratory Volume (FEV1) that is less than 80% of predicted **OR**

   C. The patient has another FDA approved indication for the requested agent and route of administration **OR**
   D. The patient has another indication that is supported in compendia for the requested agent and route of administration **AND**

2. If the patient has a diagnosis of severe asthma, ALL of the following:
   A. ONE of the following:
      1. The patient is NOT currently being treated with the requested agent AND is currently treated with a maximally tolerated inhaled corticosteroid for at least 3 months **OR**
      2. The patient is currently being treated with the requested agent AND ONE of the following:
         A. Is currently treated with an inhaled corticosteroid for at least 3 months that is adequately dosed to control symptoms **OR**

Module	Clinical Criteria for Approval
	B. Is currently treated with a maximally tolerated inhaled corticosteroid for at least 3 months **OR** 3. The patient has an intolerance or hypersensitivity to inhaled corticosteroid therapy **OR** 4. The patient has an FDA labeled contraindication to ALL inhaled corticosteroids **AND** B. ONE of the following: 1. The patient is currently being treated for at least 3 months with ONE of the following: A. A long-acting beta-2 agonist (LABA) **OR** B. A leukotriene receptor antagonist (LTRA) **OR** C. Long-acting muscarinic antagonist (LAMA) **OR** D. Theophylline **OR** 2. The patient has an intolerance or hypersensitivity to therapy with long-acting beta-2 agonists (LABA), long-acting muscarinic antagonists (LAMA), leukotriene receptor antagonist (LTRA), or theophylline **OR** 3. The patient has an FDA labeled contraindication to ALL long-acting beta-2 agonists (LABA) AND long-acting muscarinic antagonists (LAMA) **AND** C. The patient will continue asthma control therapy (e.g., ICS, ICS/LABA, LTRA, LAMA, theophylline) in combination with the requested agent **AND** 3. If the patient has an FDA labeled indication, then ONE of the following: A. The patient's age is within FDA labeling for the requested indication for the requested agent **OR** B. The prescriber has provided information in support of using the requested agent for the patient's age for the requested indication **AND** 4. The prescriber is a specialist in the area of the patient's diagnosis (e.g., allergist, immunologist, pulmonologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis **AND** 5. ONE of the following (Please refer to "Agents NOT to be used Concomitantly" table): A. The patient will NOT be using the requested agent in combination with another immunomodulatory agent (e.g., TNF inhibitors, JAK inhibitors, IL-4 inhibitors) **OR** B. The patient will be using the requested agent in combination with another immunomodulatory agent AND BOTH of the following: 1. The prescribing information for the requested agent does NOT limit the use with another immunomodulatory agent **AND** 2. The prescriber has provided information in support of combination therapy (submitted copy required, e.g., clinical trials, phase III studies, guidelines required) **AND** 6. The patient does NOT have any FDA labeled contraindications to the requested agent **Compendia Allowed:** CMS Approved Compendia **Length of Approval:** 6 months NOTE: If Quantity Limit applies, please refer to Quantity Limit Criteria. **Renewal Evaluation** **Target Agent(s)** will be approved when ALL of the following are met: 1. The patient has been previously approved for the requested agent through the plan's Prior Authorization process **AND** 2. ONE of the following: A. The patient has a diagnosis of severe asthma AND BOTH of the following: 1. The patient has had improvements or stabilization with the requested agent from baseline (prior to therapy with the requested agent) as indicated by ONE of the following:

Module	Clinical Criteria for Approval
	A. The patient has had an increase in percent predicted Forced Expiratory Volume (FEV1) **OR** B. The patient has had a decrease in the dose of inhaled corticosteroids required to control the patient's asthma **OR** C. The patient has had a decrease in need for treatment with systemic corticosteroids due to exacerbations of asthma **OR** D. The patient has had a decrease in number of hospitalizations, need for mechanical ventilation, or visits to urgent care or emergency room due to exacerbations of asthma **AND** 2. The patient is currently treated and is compliant with asthma control therapy [e.g., inhaled corticosteroids, ICS/long-acting beta-2 agonist (ICS/LABA), leukotriene receptor antagonist (LTRA), long-acting muscarinic antagonist (LAMA), theophylline] **OR** B. The patient has another FDA approved indication for the requested agent and route of administration AND has had clinical benefit with the requested agent OR C. The patient has another indication that is supported in compendia for the requested agent and route of administration AND has had clinical benefit with the requested agent **AND** 3. The prescriber is a specialist in the area of the patient's diagnosis (e.g., allergist, immunologist, pulmonologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis **AND** 4. ONE of the following (Please refer to "Agents NOT to be used Concomitantly" table): A. The patient will NOT be using the requested agent in combination with another immunomodulatory agent (e.g., TNF inhibitors, JAK inhibitors, IL-4 inhibitors) **OR** B. The patient will be using the requested agent in combination with another immunomodulatory agent AND BOTH of the following: 1. The prescribing information for the requested agent does NOT limit the use with another immunomodulatory agent **AND** 2. The prescriber has provided information in support of combination therapy (submitted copy required, e.g., clinical trials, phase III studies, guidelines required) **AND** 5. The patient does NOT have an FDA labeled contraindications to the requested agent **Compendia Allowed:** CMS Approved Compendia **Length of Approval:** 12 months NOTE: If Quantity Limit applies, please refer to Quantity Limit Criteria.

QUANTITY LIMIT CLINICAL CRITERIA FOR APPROVAL

Module	Clinical Criteria for Approval
	Evaluation **Target Agent(s)** will be approved when ONE of the following is met: 1. The requested quantity (dose) does NOT exceed the program quantity limit **OR** 2. ALL of the following: A. The requested quantity (dose) exceeds the program quantity limit **AND** B. The requested quantity (dose) does NOT exceed the maximum FDA labeled dose for the requested indication **AND** C. The requested quantity (dose) cannot be achieved with a lower quantity of a higher strength that does NOT exceed the program quantity limit **OR** 3. ALL of the following: A. The requested quantity (dose) exceeds the program quantity limit **AND** B. The requested quantity (dose) exceeds the maximum FDA labeled dose for the requested indication **AND** C. The prescriber has provided information in support of therapy with a higher dose for the requested indication **Length of approval:** Initial - 6 months; Renewal - 12 months

CONTRAINDICATION AGENTS

Contraindicated as Concomitant Therapy
Agents NOT to be used Concomitantly
Abrilada (adalimumab-afzb)
Actemra (tocilizumab)
Adalimumab
Adbry (tralokinumab-ldrm)
Amjevita (adalimumab-atto)
Arcalyst (rilonacept)
Avsola (infliximab-axxq)
Benlysta (belimumab)
Bimzelx (bimekizumab-bkzx)
Cibinqo (abrocitinib)
Cimzia (certolizumab)
Cinqair (reslizumab)
Cosentyx (secukinumab)
Cyltezo (adalimumab-adbm)
Dupixent (dupilumab)
Enbrel (etanercept)
Entyvio (vedolizumab)
Fasenra (benralizumab)
Hadlima (adalimumab-bwwd)
Hulio (adalimumab-fkjp)
Humira (adalimumab)
Hyrimoz (adalimumab-adaz)
Idacio (adalimumab-aacf)
Ilaris (canakinumab)

Contraindicated as Concomitant Therapy
Ilumya (tildrakizumab-asmn)
Inflectra (infliximab-dyyb)
Infliximab
Kevzara (sarilumab)
Kineret (anakinra)
Litfulo (ritlecitinib)
Nucala (mepolizumab)
Olumiant (baricitinib)
Omvoh (mirikizumab-mrkz)
Opzelura (ruxolitinib)
Orencia (abatacept)
Otezla (apremilast)
Remicade (infliximab)
Renflexis (infliximab-abda)
Riabni (rituximab-arrx)
Rinvoq (upadacitinib)
Rituxan (rituximab)
Rituxan Hycela (rituximab/hyaluronidase human)
Ruxience (rituximab-pvvr)
Siliq (brodalumab)
Simponi (golimumab)
Simponi ARIA (golimumab)
Skyrizi (risankizumab-rzaa)
Sotyktu (deucravacitinib)
Stelara (ustekinumab)
Taltz (ixekizumab)
Tezspire (tezepelumab-ekko)

Contraindicated as Concomitant Therapy
Tremfya (guselkumab)
Truxima (rituximab-abbs)
Tysabri (natalizumab)
Velsipity (etrasimod)
Wezlana (ustekinumab-auub)
Xeljanz (tofacitinib)
Xeljanz XR (tofacitinib extended release)
Xolair (omalizumab)
Yuflyma (adalimumab-aaty)
Yusimry (adalimumab-aqvh)
Zeposia (ozanimod)
Zymfentra (infliximab-dyyb)