maryland physicians care
Medicaid with a Heart

PRIOR AUTHORIZATION REQUEST

Tezspire

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll-free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please note that supporting clinical documentation is required for **ALL** PA requests.

1	Is the patient greater than or equal to 12 years of age? [If no, no further questions.]	Yes	No
2	What is the diagnosis or indication? [] Asthma (If checked, go to 3) [] Other (If checked, no further questions)		
3	Is the request for initial or continuation of therapy? [] Initial (If checked, go to 5) [] Continuation (If checked, go to 4)		

If you have any questions, call:
1-888-258-8250

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4	Has the patient already received AT LEAST 3 months of therapy with the requested medication? [Note: A patient who has received LESS THAN 3 months of therapy or who is restarting therapy with the requested medication should be considered under initial therapy.] [] 3 months or more (If checked, go to 19) [] Less than 3 months (If checked, go to 5)		
5	Has the patient received AT LEAST 3 consecutive months of combination therapy with BOTH of the following: A) An inhaled corticosteroid at maximum doses AND B) AT LEAST ONE additional asthma controller OR asthma maintenance medication? [Note: Examples of additional asthma controller or asthma maintenance medications are inhaled long-acting beta2-agonists, inhaled long- acting muscarinic antagonists, leukotriene receptor antagonists, anti-interleukin-5 therapies (for example, Cinqair [reslizumab intravenous infusion], Fasenra [benralizumab subcutaneous injection], Nucala [mepolizumab subcutaneous injection]), Dupixent (dupilumab subcutaneous injection), Xolair (omalizumab subcutaneous injection), and theophylline. Use of a combination inhaler containing both an inhaled corticosteroid and a long-acting beta2-agonist would fulfill the requirement for both criteria A and B.] [If no, no further questions.]	Yes	No
6	Does the patient have a documented intolerance, contraindication to, or failed treatment for AT LEAST 4 months of therapy with Xolair? [If no, no further questions.]	Yes	No
7	Does the patient have asthma that is uncontrolled or was uncontrolled at baseline as defined by the following: patient experienced two or more asthma exacerbations requiring treatment with systemic corticosteroids in the previous year? [Note: "Baseline" is defined as prior to receiving any Tezspire, anti-interleukin-5 therapies (that is, Cinqair, Fasenra, or Nucala), Dupixent, or Xolair.] [If yes, skip to question 12.]	Yes	No
8	Does the patient have asthma that is uncontrolled or was uncontrolled at baseline as defined by the following: patient experienced one or more asthma exacerbation(s) requiring hospitalization, an Emergency Department visit, or an urgent care visit in the previous year? [Note: "Baseline" is defined as prior to receiving any Tezspire, anti-interleukin-5 therapies (that is, Cinqair, Fasenra, or Nucala), Dupixent, or Xolair.] [If yes, skip to question 12.]	Yes	No
9	Does the patient have asthma that is uncontrolled or was uncontrolled at baseline as defined by the following: patient has a forced expiratory volume in 1 second (FEV1) LESS THAN 80% predicted?	Yes	No

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	[Note: "Baseline" is defined as prior to receiving any Tezspire, anti-interleukin-5 therapies (that is, Cinqair, Fasenra, or Nucala), Dupixent, or Xolair.] [If yes, skip to question 12.]		
10	Does the patient have asthma that is uncontrolled or was uncontrolled at baseline as defined by the following: patient has an FEV1/forced vital capacity (FVC) LESS THAN 0.80? [Note: "Baseline" is defined as prior to receiving any Tezspire, anti-interleukin-5 therapies (that is, Cinqair, Fasenra, or Nucala), Dupixent, or Xolair.] [If yes, skip to question 12.]	Yes	No
11	Does the patient have asthma that is uncontrolled or was uncontrolled at baseline as defined by the following: the patient has asthma that worsens upon tapering of oral corticosteroid therapy? [Note: "Baseline" is defined as prior to receiving any Tezspire, anti- interleukin-5 therapies (that is, Cinqair, Fasenra, or Nucala), Dupixent, or Xolair.] [If no, no further questions.]	Yes	No
12	Will the requested medication be used in combination with anti-IgE, anti- IL4, or anti-IL5 monoclonal antibody agents (benralizumab, omalizumab, mepolizumab, reslizumab, dupilumab, et cetera)? [If yes, no further questions.]	Yes	No
13	Will the requested medication be administered concurrently with live vaccines? [If yes, no further questions.]	Yes	No
14	Will the requested medication be used for the relief of acute bronchospasm or status asthmaticus? [If yes, no further questions.]	Yes	No
15	Do the patient and provider agree that the requested medication WILL NOT be used as monotherapy AND WILL be used as an add on maintenance treatment with an inhaled corticosteroid? [If no, no further questions.]	Yes	No
16	Does the patient have an active or untreated helminth infection? [If yes, no further questions.]	Yes	No
17	Does the requested dose exceed Food and Drug Administration (FDA) approved label dosing for this indication? [If yes, no further questions.]	Yes	No
18	Is the requested medication being prescribed by or in consultation with an allergist, immunologist, or pulmonologist? [No further questions.]	Yes	No
19	Has the patient continued to receive therapy with one inhaled corticosteroid OR one inhaled corticosteroid-containing combination inhaler?	Yes	No

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	[If no, no further questions.]		
20	Will the requested medication be used in combination with anti-IgE, anti-IL4, OR anti-IL5 monoclonal antibody agents (benralizumab, omalizumab, mepolizumab, reslizumab, dupilumab, et cetera)? [If yes, no further questions.]	Yes	No
21	Will the requested medication be administered concurrently with live vaccines? [If yes, no further questions.]	Yes	No
22	Does the patient have active or untreated helminth infection? [If yes, no further questions.]	Yes	No
23	Does the requested dose exceed Food and Drug Administration (FDA) approved label dosing for this indication? [If yes, no further questions.]	Yes	No
24	Has documentation been submitted to confirm that patient has clinical improvement of FEV1 from baseline? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
25	Has documentation been submitted to confirm that the patient has responded to therapy as determined by the prescriber? ACTION REQUIRED: Submit supporting documentation. [Note: Examples of a response to Tezspire therapy are decreased asthma exacerbations; decreased asthma symptoms; decreased hospitalizations, emergency department/urgent care, or medical clinic visits due to asthma; improved lung function parameters; and/or a decreased requirement for oral corticosteroid therapy].	Yes	No

Please document the diagnoses, symptoms, and/or any other information important to this review:

SECTION B: Physician Signature

PHYSICIAN SIGNATURE DATE

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FAX COMPLETED FORM TO: 1-833-896-0656

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

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