# PRIOR AUTHORIZATION REQUEST

## Tezspire

**Patient Information:**

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

**Prescriber Information:**

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

**Requested Medication**

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| 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. Pharmacy prior authorization reviews can be subject to trial with additional medications that are not listed within the criteria. The policies are subject to change based on COMAR requirements, MDH transmittals and updates to treatment guidelines.

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| 1 | Is the request an INITIAL or CONTINUATION of therapy?<br>[] Initial (If checked, go to 7)<br>[] Continuation (If checked, go to 2) | | |
| 2 | Is the patient currently receiving the request medication and taking it with one inhaled corticosteroid OR one inhaled corticosteroid-containing combination | Yes | No |

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| | inhaler?<br><br>[If no, skip to question 7.] | | |
| 3 | Has the patient been receiving medication samples of the requested medication?<br><br>[If yes, skip to question 7.] | Yes | No |
| 4 | Does the patient have a previously approved prior authorization (PA) on file with the current plan?<br><br>[Note: If the patient does NOT have a previously approved PA on file for the requested medication with the current plan, the renewal request will be considered under initial therapy.]<br><br>[If no, skip to questions 7.] | Yes | No |
| 5 | Will the patient be concurrently receiving the requested medication in combination with any anti-IgE, anti-IL4, OR anti-IL5 monoclonal antibody agents (benralizumab, omalizumab, mepolizumab, reslizumab, dupilumab, et cetra)?<br><br>[If yes, no further questions.] | Yes | No |
| 6 | Has documentation been submitted to confirm that the patient has responded to therapy as determined by the prescriber? ACTION REQUIRED: Submit supporting documentation.<br><br>[Note: Examples of a response to Tezspire therapy are improvement in FEV1 from baseline, 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.]<br><br>[No further questions.] | Yes | No |
| 7 | What is the indication?<br><br>[] Asthma (If checked, go to 8)<br><br>[] Other (If checked, no further questions) | | |
| 8 | Is the patient 12 years of age or older?<br><br>[If no, no further questions.] | Yes | No |
| 9 | Is the requested medication being prescribed by or in consultation with an allergist, | Yes | No |

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| | immunologist, or pulmonologist?<br><br>[If no, no further questions.] | | |
| 10 | 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?<br><br>[Note: "Baseline" is defined as prior to receiving any Tezspire, anti-interleukin-5 therapies (that is, Cinqair, Fasenra, or Nucala), Dupixent, or Xolair.]<br><br>[If yes, skip to question 14.] | Yes | No |
| 11 | 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?<br><br>[Note: "Baseline" is defined as prior to receiving any Tezspire, anti-interleukin-5 therapies (that is, Cinqair, Fasenra, or Nucala), Dupixent, or Xolair.]<br><br>[If yes, skip to question 14.] | Yes | No |
| 12 | 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?<br><br>[Note: "Baseline" is defined as prior to receiving any Tezspire, anti-interleukin-5 therapies (that is, Cinqair, Fasenra, or Nucala), Dupixent, or Xolair.]<br><br>[If yes, skip to question 14.] | Yes | No |
| 13 | 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?<br><br>[Note: "Baseline" is defined as prior to receiving any Tezspire, anti-interleukin-5 therapies (that is, Cinqair, Fasenra, or Nucala), Dupixent, or Xolair.]<br><br>[If no, no further questions.] | Yes | No |
| 14 | 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?<br><br>[Note: "Baseline" is defined as prior to receiving any Tezspire, anti- interleukin-5 therapies (that is, Cinqair, Fasenra, or Nucala), Dupixent, or Xolair.]<br><br>[If no, no further questions.] | Yes | No |

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| 15 | 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)?<br>[If yes, no further questions.] | Yes | No |
| 16 | Will the requested medication be administered concurrently with live vaccines?<br>[If yes, no further questions.] | Yes | No |
| 17 | Will the requested medication be used for the relief of acute bronchospasm or status asthmaticus?<br>[If yes, no further questions.] | Yes | No |
| 18 | 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?<br>[If no, no further questions.] | Yes | No |
| 19 | Does the patient have an active or untreated helminth infection?<br>[If yes, no further questions.] | Yes | No |
| 20 | Does the patient have a documented intolerance, contraindication to, or failed treatment for AT LEAST 4 months of therapy with Xolair?<br>[If no, no further questions.] | Yes | No |
| 21 | Has documentation been submitted to confirm that the patient has had an intolerance, contraindication to, or failed treatment for at least 3 months with preferred IL-4 and IL13R inhibitor, Dupixent? ACTION REQUIRED: Submit supporting documentation.<br>[If no, no further questions.] | Yes | No |
| 22 | Has documentation been submitted to confirm that the patient has had an intolerance, contraindication to, or failed treatment for at least 3 months with IL-5 inhibitor, Nucala? ACTION REQUIRED: Submit supporting documentation.<br>[If no, no further questions.] | Yes | No |
| 23 | Does the requested dose exceed Food and Drug Administration (FDA) approved | Yes | No |

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| | label dosing for this indication?<br>[Note: Dosing is 210 mg once every 4 weeks] | | |

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

SECTION B: Physician Signature

PHYSICIAN SIGNATURE DATE

**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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