AmeriHealth Caritas North Carolina

Pharmacy Request for Prior Approval – Tezspire

Beneficiary Information

1. Beneficiary Last Name: _____ 2. First Name: _____
3. Beneficiary ID #: _____ 4. Beneficiary Date of Birth: _____ 5. Beneficiary Gender: _____

Prescriber Information

6. Prescriber Name: _____ NPI #: _____
Mailing address: _____ City: _____ State: _____ ZIP: _____
7. Requester Contact Information: _____
Name: _____ Phone #: _____ Fax #: _____

Drug Information

8. Drug Name: _____ 9. Strength: _____ 10. Quantity Per 30 Days: _____
11. Length of Therapy: ___up to 30 days ___60 days ___90 days ___120 days ___180 days ___365 days ___Other:_____

Clinical Information

Initial Approval **Initial approval can be for up to 6 months**

1. Is the beneficiary 12 years of age or older? Yes___ No___
2. Does the beneficiary have a diagnosis of severe asthma with evidence of severe disease? Yes___ No___
3. Does the beneficiary have at least 1 of the following? Yes___ No___ **Please indicate which one:** _____
   a. Symptoms throughout the day
   b. Nighttime awakenings, often 7x/week
   c. SABA use for symptom control occurring several times per day
   d. Extremely limited normal activities
   e. Lung function (percent predicted FEV1) < 60%
   f. Exacerbations requiring oral systemic corticosteroids generally more frequent and intense relative to moderate asthma
4. Is Tezspire being used for add-on maintenance treatment for a beneficiary who regularly received BOTH of the following? Yes___ No___
   a. Medium- to high-dose inhaled corticosteroids
   b. An additional controller medication (e.g., long-acting beta-agonist, leukotriene modifiers)
5. Has the beneficiary had, in the previous year, ≥ 2 exacerbations requiring oral or injectable corticosteroid treatment (in addition to the regular maintenance therapy defined above) **OR** one exacerbation resulting in hospitalization? Yes___ No___
6. Is there a baseline measurement of ≥ 1 of the following for assessment of clinical status? Yes___ No___

Please indicate which one(s): _____

   a. Use of systemic corticosteroids
   b. Use of inhaled corticosteroids
   c. Number of hospitalizations, ER visits, or unscheduled visits to healthcare provider due to condition
   d. FEV1
7. Will the beneficiary use Tezspire for the relief of acute bronchospasm or status asthmaticus? Yes___ No___
8. Will the beneficiary use Tezspire in combination with anti-IgE, anti-IL4, or anti-IL5 monoclonal antibody agents (e.g., benralizumab, omalizumab, mepolizumab, reslizumab, dupilumab)? Yes___ No___
9. Does the beneficiary have hypersensitivity to tezepelumab-ekko (Tezspire) or any of its excipients? Yes___ No___
10. Does the beneficiary have an active or untreated helminth infection? Yes___ No___
11. Will Tezspire be administered concurrently with live vaccines? Yes___ No___

For continuation of therapy, please answer questions 1-13 **Reauthorizations can be for up to 6 months**

12. While on Tezspire, has the beneficiary experienced an improvement in asthma symptoms, asthma exacerbations, or airway function as evidenced by a decrease in ≥ 1 of the following? Yes___ No___ **Please indicate which one(s):** _____
   a. Use of systemic corticosteroids
   b. Two-fold or greater decrease in inhaled corticosteroid use for at least 3 days
   c. Hospitalizations
   d. ER visits
   e. Unscheduled visits to healthcare provider
   f. Improvement from baseline in FEV1
13. Has the beneficiary experienced any serious treatment-related adverse events (e.g., parasitic [helminth] infection, severe hypersensitivity reactions)? Yes___ No___

**** Please provide medical records documenting the beneficiary's current Asthma status and response to Tezspire treatment ****

Signature of Prescriber: _____ Date: _____

***Prescriber signature mandatory**

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to: 1-877-234-4274, or call Pharmacy Prior Authorization: 1-866-885-1406