

Request for Prior Authorization

TEZPELUMAB-EKKO**(TEZSPIRE)****PREFILLED PEN**

(PLEASE PRINT – ACCURACY IS IMPORTANT)

High-Dose ICS Trial:

Drug name & dose: _____ Trial dates: _____

Failure reason: _____

Controller Medication Trial:

Drug name & dose: _____ Trial dates: _____

Failure reason: _____

Does patient have one of the following?

Two (2) or more asthma exacerbations requiring oral or injectable corticosteroid treatment in the previous 12 months?

 Yes NoOne or more asthma exacerbations resulting in hospitalization in the previous 12 months? Yes NoWill this medication be used as an add-on maintenance treatment? Yes NoWill medication be administered in patient's home? Yes NoWill medication be prescribed in combination with other biologics? Yes No CRSwNPWill this medication be used as an add-on maintenance treatment? Yes No**Nasal Corticosteroid Spray Trial:**

Drug name & dose: _____ Trial dates: _____

Failure reason: _____

Oral Corticosteroid Trial:

Drug name & dose: _____ Trial dates: _____

Failure reason: _____

Renewals:

Document positive response to therapy: _____

Medical or contraindication reason to override trial requirements: _____

Attach lab results and other documentation as necessary.

Prescriber signature (Must match prescriber listed above.)

Date of submission

IMPORTANT NOTE: In evaluating requests for prior authorization, the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary, by contact with the county Department of Health and Human Services, that the member continues to be eligible for Medicaid.