



### Request for Prior Authorization TEZPELUMAB-EKKO (TEZSPIRE) PREFILLED PEN

(PLEASE PRINT – ACCURACY IS IMPORTANT)

IA Medicaid Member ID #	Patient name	DOB
Patient address		
Provider NPI	Prescriber name	Phone
Prescriber address		Fax
Pharmacy name	Address	Phone
<b>Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.</b>		
Pharmacy NPI	Pharmacy fax	NDC

**Prior authorization (PA) is required for tezepelumab-ekko (Tezspire) prefilled pen. Requests for tezepelumab-ekko (Tezspire) single dose vial or prefilled syringe will not be considered through the pharmacy benefit. Payment will be considered for an FDA approved or compendia indicated diagnosis for the requested drug when the following conditions are met:**

1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and
2. Patient has a diagnosis of severe asthma; and
  - a. Symptoms are inadequately controlled with documentation of current treatment with a high-dose inhaled corticosteroid (ICS) given in combination with a controller medication (e.g., long-acting beta2 agonist [LABA], leukotriene receptor agonist [LTRA], oral theophylline) for a minimum of 3 consecutive months. Patient must be compliant with therapy, based on pharmacy claims; and
  - b. Patient must have one of the following, in addition to the regular maintenance medications defined above:
    - i. Two or more asthma exacerbations requiring oral or injectable corticosteroid treatment in the previous 12 months; or
    - ii. One or more asthma exacerbations resulting in hospitalization in the previous 12 months; and
  - c. This medication will be used as an add-on maintenance treatment; and
  - d. Patient/caregiver will administer medication in patient’s home; and
  - e. Is not prescribed in combination with other biologics indicated for asthma.

If criteria for coverage are met, initial authorization will be given for 6 months to assess the response to treatment. Requests for continuation of therapy will require documentation of a positive response to therapy.

The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

**Non-Preferred**

Tezspire Prefilled Pen

**Strength** \_\_\_\_\_ **Dosage Instructions** \_\_\_\_\_ **Quantity** \_\_\_\_\_ **Days Supply** \_\_\_\_\_

**Diagnosis:** \_\_\_\_\_

**Document current treatment with a high-dose ICS given in combination with a controller medication:**

**High-Dose ICS Trial:**

Drug name & dose: \_\_\_\_\_ Trial dates: \_\_\_\_\_

Failure reason: \_\_\_\_\_

**Controller Medication Trial:**

Drug name & dose: \_\_\_\_\_ Trial dates: \_\_\_\_\_

Failure reason: \_\_\_\_\_



Fax Completed Form To

1.833.404.2392

Prescriber Help Desk

1.833.587.2012

Online

[covermyeds.com/main/prior-authorization-forms/](http://covermyeds.com/main/prior-authorization-forms/)

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**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  No

One or more asthma exacerbations resulting in hospitalization in the previous 12 months?  Yes  No

Will this medication be used as an add-on maintenance treatment?  Yes  No

Will medication be administered in patient’s home?  Yes  No

Will medication be prescribed in combination with other biologics?  Yes  No

**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
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**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.