HEALTHY U CHIP

PRIOR AUTHORIZATION REQUEST FORM
TEZSPIRE™

For authorization, please answer each question and fax this form PLUS chart notes back to the Healthy U CHIP Prior Authorization Department at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance: 385-425-5094

Disclaimer: Prior Authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: ☐ Tezspire™ (tezepelumab-ekko)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section.

Questions	Yes	No	Comments/Notes
SEVERE ASTHMA			
1. Does the member have a diagnosis of severe asthma and documentation of at least one of the following: • Symptoms throughout the day • Nighttime awakenings, often 7 times per week • SABA use for symptom control occurs several times per day • Extremely limited normal activities • Lung function (percent predicted FEV1) <60%	☐	☐	**Please provide documentation**
2. Is the request made by an asthma specialist (allergist, immunologist, or pulmonologist)?	☐	☐	**Please provide documentation**
3. Is Tezspire™ used as an add-on maintenance treatment to routine maintenance treatment that includes both of the following: • A medium to high-dose inhaled corticosteroid • One other controller medication (e.g., long-acting beta agonist, leukotriene modifiers, etc.)	☐	☐	**Please provide documentation**
4. Does clinical documentation show the member is ≥ 80% compliant for at least 5 months with prescribed inhalers?	☐	☐	**Please provide documentation**
5. Does clinical documentation show poor asthma control, defined by the following: • ≥2 acute exacerbations in a 12-month period requiring additional medical treatment, including emergency	☐	☐	**Please provide documentation**

department (ED) visits, hospitalizations, or frequent office visits, etc.			
6. Does the member have a baseline forced expiratory volume in 1 second (FEV_1) < 80%? • Note: For members age 12 to 17, FEV_1 must be < 90%	☐	☐	**Please provide documentation**
7. Does the member have a medical reason that they cannot use Dupixent® (dupilumab), anti-IL5 agents (i.e., Fasenra® (benralizumab)) and Xolair® (omalizumab) such as: • Trial and failure or contraindication/intolerance to all agents • Member does not meet Dupixent® and anti-IL5 agents criteria based on eosinophil count and member does not meet Xolair® criteria based on IgE levels and/or aeroallergen skin test	☐	☐	**Please provide documentation**
8. Will Tezspire™ be used in combination with anti-IL4, anti-IL5, or anti-IgE monoclonal antibody agents?	☐	☐	**Please provide documentation**
9. Is smoking cessation addressed, if applicable?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the requesting for reauthorization of therapy?	☐	☐	**Please provide documentation**
2. Does clinical documentation show a positive clinical response to therapy with improvement from baseline?	☐	☐	**Please provide documentation**
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			
Additional information:			
Physician Signature:			

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Policy: PHARM-CHIP-157
Origination Date: 07/01/2024
Reviewed/Revised Date:
Next Review Date:
Current Effective Date: 07/01/2024