

**Tezspire<sup>®</sup> (tezepelumab-ekko) Prior Authorization Form****Member Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ **Member ID#:** \_\_\_\_\_**Drug Information** **Physician billing (HCPCS code:** \_\_\_\_\_ **)**  **Pharmacy billing (NDC:** \_\_\_\_\_ **)****Dose:** \_\_\_\_\_ **Regimen:** \_\_\_\_\_ **Fill Date:** \_\_\_\_\_**Billing Provider Information****Provider NPI:** \_\_\_\_\_ **Provider Name:** \_\_\_\_\_**Provider Phone:** \_\_\_\_\_ **Provider Fax:** \_\_\_\_\_**Prescriber Information****Prescriber NPI:** \_\_\_\_\_ **Prescriber Name:** \_\_\_\_\_**Prescriber Phone:** \_\_\_\_\_ **Prescriber Fax:** \_\_\_\_\_ **Specialty:** \_\_\_\_\_**Clinical Information****For Initial Authorization:** *(Initial approvals will be for the duration of 6 months)*1. For authorization of Tezspire<sup>®</sup> in a health care facility, will the injection be administered by a health care provider prepared to manage anaphylaxis? Yes \_\_\_ No \_\_\_2. For authorization of Tezspire<sup>®</sup> pre-filled pen for self-administration, will the injection be administered by a health care provider prepared to manage anaphylaxis or the member or caregiver has been trained by a health care professional on subcutaneous administration, monitoring for any allergic reactions, and storage of Tezspire<sup>®</sup>?  
Yes \_\_\_ No \_\_\_3. Will Tezspire<sup>®</sup> be used as add-on maintenance treatment? Yes \_\_\_ No \_\_\_

A. If yes, please indicate member's daily medications and dose prescribed for treatment of this diagnosis:

Drug/Dose: \_\_\_\_\_ Drug/Dose: \_\_\_\_\_

4. Was Tezspire<sup>®</sup> prescribed by a specialist or has the member been evaluated by a specialist within the last 12 months (or an advanced care practitioner with a supervising physician who is specialist)? Yes \_\_\_ No \_\_\_

A. If "Yes", please indicate name of specialist: \_\_\_\_\_ Specialty: \_\_\_\_\_

5. Please indicate the diagnosis and information:

 **Severe Asthma**A. Has the member experienced  $\geq$  two asthma exacerbations requiring oral or injectable corticosteroids, or that resulted in hospitalization in the last 12 months? Yes \_\_\_ No \_\_\_

i. If yes, please indicate dates/details: \_\_\_\_\_

B. Has member failed a medium-to-high dose inhaled corticosteroid (ICS) used compliantly within the last 3-6 consecutive months? Yes \_\_\_ No \_\_\_

i. If yes, please indicate medication/dates: \_\_\_\_\_

C. Has the member failed at least 1 other asthma controller medication used in addition to the medium-to-high dose ICS compliantly for at least the past 3 months? Yes \_\_\_ No \_\_\_

i. If yes, please indicate medication/dates: \_\_\_\_\_

**(Page 1 of 2)****PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:**University of Oklahoma College of Pharmacy  
Pharmacy Management Consultants  
Product Based Prior Authorization Unit  
Fax: 1-800-224-4014  
Phone: 1-800-522-0114 Option 4**CONFIDENTIALITY NOTICE***This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.*

**Tezspire® (tezepelumab-ekko) Prior Authorization Form****Member Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ **Member ID#:** \_\_\_\_\_**Clinical Information****For Initial Authorization:** *(Initial approvals will be for the duration of 6 months)*5. Please indicate the diagnosis and information: *(continued)* **Chronic Rhinosinusitis with Nasal Polyps (CRSwNP)**

- A. Is CRSwNP inadequately controlled? Yes \_\_\_ No \_\_\_
- B. Does the member have a trial with an intranasal corticosteroid that resulted in failure? Yes \_\_\_ No \_\_\_
- i. If yes, please indicate medication used and dates of use: \_\_\_\_\_
- ii. If no, does member have a contraindication or documented intolerance? Yes \_\_\_ No \_\_\_
- C. Has member required prior sino-nasal surgery? Yes \_\_\_ No \_\_\_
- D. Has member previously been treated with systemic corticosteroids in the past 2 years (or has a contraindication or documented intolerance)? Yes \_\_\_ No \_\_\_
- i. If yes, please indicate medication/dates: \_\_\_\_\_
- ii. If no, does member have a contraindication or documented intolerance? Yes \_\_\_ No \_\_\_
- a. If yes, please provide details: \_\_\_\_\_
- E. Has member had symptoms of chronic rhinosinusitis (e.g., facial pain/pressure, reduction or loss of smell, nasal blockade/obstruction/congestion, nasal discharge) for 12 weeks or longer despite attempts at medical management? Yes \_\_\_ No \_\_\_
- F. Does member have evidence of nasal polyposis by direct examination, sinus CT scan, or endoscopy? Yes \_\_\_ No \_\_\_
- G. Will the member continue to receive intranasal corticosteroid therapy? Yes \_\_\_ No \_\_\_
- i. If no, does the member have a contraindication to intranasal corticosteroid therapy? Yes \_\_\_ No \_\_\_
- a. If yes, please provide the member's contraindication: \_\_\_\_\_

 **Other:** \_\_\_\_\_**For Continued Authorization:**

1. Is the member compliant with therapy? Yes \_\_\_ No \_\_\_
2. Is the member responding well to therapy? Yes \_\_\_ No \_\_\_

**Additional Information:** \_\_\_\_\_*(Page 2 of 2)***Prescriber Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_*(By signature, the physician confirms the criteria information above is accurate and verifiable in patient records.)***Pharmacist Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_*Failure to complete this form in full will result in processing delays. Please do not send in chart notes. Specific information will be requested if necessary.***PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:**University of Oklahoma College of Pharmacy  
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