

Tezspire[®] (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[®] 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[®] 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[®]?
Yes ___ No ___

3. Will Tezspire[®] 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[®] 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

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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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