

TEZSPIRE[®] (tezepelumab ekko) Prior Authorization (PA) Form

Virginia | HealthKeepers, Inc. | Anthem HealthKeepers Plus Medicaid products

If the following information is not complete, correct, or legible, the PA process can be delayed. Please use one form per member.

Member information

Last name:

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First name:

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Medicaid ID number:

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Date of birth:

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Weight in kilograms: _____

Prescriber information

Last name:

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First name:

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NPI number:

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Phone number:

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Fax number:

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Drug information

Drug name:	_____	Drug form:	_____
Drug strength:	_____	Dosing frequency:	_____
Length of therapy:	_____	Quantity per day:	_____

The Virginia Department of Medical Assistance Services (DMAS) considers the use of concomitant therapy with Cinqair®, Dupixent®, Fasenra®, Nucala®, Tezspire™, and Xolair® to be experimental and investigational. The safety and efficacy of these combinations have not been established and will not be permitted.

(Form continued next page.)

Member's last name:

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Member's first name:

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Diagnosis and medical information

For severe* asthma initial approval, complete the following questions to receive a six-month approval:

1. Is the member 12 years of age or older? AND
 Yes No
2. Does the member have a diagnosis of severe* asthma? AND
 Yes No
3. Will coadministration with another monoclonal antibody be avoided (for example, omalizumab, mepolizumab, reslizumab, benralizumab, dupilumab)? AND
 Yes No
4. Will this be used for add-on maintenance treatment in members regularly receiving both (unless otherwise contraindicated) of the following:
 - Medium- to high-dose inhaled corticosteroids; AND
 - An additional controller medication (for example, long-acting beta agonist, leukotriene modifiers)? Yes No
5. Has the member had two or more exacerbations in the previous year requiring oral or injectable corticosteroid treatment (in addition to the regular maintenance therapy defined above) or one exacerbation resulting in a hospitalization? AND
 Yes No
6. Does the member have at least one of the following for assessment of clinical status:
 - Use of systemic corticosteroids
 - Use of inhaled corticosteroids
 - Number of hospitalizations, ER visits, or unscheduled visits to healthcare provider due to condition
 - Forced expiratory volume in 1 second (FEV₁)? AND Yes No

(Form continued next page.)

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Member's last name:

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Member's first name:

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7. Has the member tried and failed an adequate trial of the 2 different preferred products (Fasenra® and Xolair®)?

Yes No N/A

If N/A was selected for question 7, please answer the following:

a) Does the member lack an eosinophilic phenotype with blood eosinophils ≥ 150 cells/ μ L?
AND

Yes No

b) Does the member have a serum IgE level < 30 IU/mL? OR

Yes No

c) Does the member have another predicted intolerance to the preferred agents? (Answer below)

Yes No

(Form continued next page.)

Member's last name:

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Member's first name:

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For severe* asthma renewal, complete the following questions to receive a 12-month approval:

1. Has the member been assessed for toxicity? AND
 Yes No

2. Does the member have improvement in asthma symptoms or asthma exacerbations as evidenced by a decrease in one or more of the following:
 - Use of systemic corticosteroids
 - Hospitalizations
 - ER visits
 - Unscheduled visits to healthcare provider
 - Improvement from baseline in forced expiratory volume in 1 second (FEV₁)? Yes No

* Components of severity for classifying asthma as severe may include any of the following (not all-inclusive):

- Asthma that remains uncontrolled despite optimized treatment with high-dose ICS-LABA
- Asthma that requires high-dose ICS-LABA to prevent it from being uncontrolled
- Symptoms throughout the day
- Nighttime awakenings, often seven times/week
- SABA use for symptom control occurs several times per day
- Extremely limited normal activities
- Lung function (percent predicted FEV₁) < 60%
- Exacerbations requiring oral systemic corticosteroids are generally more frequent and intense relative to moderate asthma

(Form continued next page.)

Member's last name:

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Member's first name:

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For chronic rhinosinusitis with nasal polyps (CRSwNP) initial approval, complete the following questions to receive a 6-month approval:

1. Is the member 12 years of age or older? AND
 Yes No
2. Does the member have a diagnosis of bilateral symptomatic sino-nasal polyposis with symptoms lasting at least 8 weeks? AND
 Yes No
3. Will coadministration with another monoclonal antibody be avoided (e.g., omalizumab, mepolizumab, reslizumab, benralizumab, dupilumab)? AND
 Yes No
4. Has the member tried and failed an 8-week trial of intranasal corticosteroid therapy? AND
 Yes No
5. Will Tezspire be used in combination with intranasal corticosteroids (unless intolerant or contraindicated)? AND
 Yes No
6. Has the member tried and failed an adequate trial of the preferred product, Xolair (unless contraindicated or clinically inappropriate)?
 Yes No

(Form continued next page.)

For chronic rhinosinusitis with nasal polyps renewal, complete the following questions to receive a 12-month approval:

1. Has the member been assessed for toxicity? AND
 Yes No

2. Has the member experienced a disease response as indicated by improvement in signs and symptoms compared to baseline in one or more of the following: nasal/obstruction symptoms, improvement of sinus opacifications as assessed by CT-scans and/or an improvement on a disease activity scoring tool (for example, nasal polyposis score [NPS], nasal congestion [NC] symptom severity score, sinonasal outcome test-22 [SNOT-22])? OR
 Yes No

3. Did the member have improvement in at least one of the following response criteria:
 - Reduction in nasal polyp size
 - Reduction in need for systemic corticosteroids
 - Improvement in quality of life
 - Improvement in sense of smell
 - Reduction of impact of comorbidities? Yes No

Prescriber signature (required)

Date

By signature, the physician confirms the above information is accurate and verifiable by member records. Please include all requested information; Incomplete forms will delay the PA process. Submission of documentation does not guarantee coverage. The completed form may be faxed to **844-512-7020**.