Part B Prior Authorization Guidelines

Asthma (non-specific)

Tezspire (Tezepelumab-ekko) J2356

Prior Authorization Request

Medicare Part B Form

*Instructions: * Indicates required information – Form may be returned if required information is not provided. Please fax this request to the appropriate fax number listed at the bottom of the page.*

☐	**Standard Request– (72 Hours)**	☐	**Urgent Request** (standard time frame could place the member's life, health or ability in serious jeopardy)
	Date Requested _____		
	Requestor _____ Clinic name: _____ Phone / Fax		

MEMBER INFORMATION

*Name:_____ *ID#:_____ *DOB:_____

PRESCRIBER INFORMATION

*Name:_____ ☐MD ☐FNP ☐DO ☐NP ☐PA *Phone:_____

*Address:_____ *Fax:_____

DISPENSING PROVIDER / ADMINISTRATION INFORMATION

*Name:_____ Phone:_____

*Address:_____ Fax:_____

PROCEDURE / PRODUCT INFORMATION

HCPC Code	Name of Drug	Dose (Wt: _____ kg Ht:_____)	Frequency	End Date if known

☐ **Self-administered** ☐ **Provider-administered** ☐ **Home Infusion**

☐Chart notes attached. **Other important information:**_____

Diagnosis: ICD10: _____ **Description**: _____

☐ Provider attests the diagnosis provided is an FDA-Approved indication for this drug

CLINICAL INFORMATION

☐ New Start or Initial Request: (Clinical documentation required for all requests)

☐ Patient has a diagnosis of severe asthma; AND

☐ Evidence of asthma is demonstrated by the following:

- ☐ A pretreatment forced expiratory volume in 1 second (FEV1) less than 80% predicted; AND
- ☐ FEV1 reversibility of at least 12% and 200 milliliters after albuterol administration; AND

☐ Documentation is provided that Patient has had a 3 month trial and inadequate response or intolerance to combination controller therapy (high dose inhaled corticosteroids plus long acting beta2 –agonists, leukotriene modifiers, long-acting muscarinic antagonists or oral corticosteroids); AND

☐ Patient has experienced two or more asthma exacerbations in the prior 12 months requiring use of a systemic corticosteroid or temporary increase in the Patient's usual maintenance dosage of oral corticosteroids.

- Tezspire (tezepelumab-ekko) may NOT be approved In combination with Cinqair, Dupixent, Fasenra, Nucala or Xolair;

☐ Continuation Requests: (Clinical documentation required for all requests)

☐ Treatment with Tezspire has resulted in clinical improvement in one or more of the following:

- ☐ Decreased utilization of rescue medications; OR
- ☐ Decreased frequency of exacerbations (defined as worsening of asthma that requires an increase in inhaled corticosteroid dose or treatment with systemic corticosteroids); OR
- ☐ Increase in percent predicted FEV1 from pretreatment baseline; OR
- ☐ Reduction in reported asthma-related symptoms, including asthmatic symptoms upon awakening, coughing, fatigue, shortness of breath, sleep disturbance or wheezing.

ACKNOWLEDGEMENT

Request By (Signature Required): _____Date:_____ /____ /____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. **THIS AUTHORIZATION IS NOT A GUARANTEE OF PAYMENT.** PAYMENT IS BASED ON BENEFITS IN EFFECT AT THE TIME OF SERVICE, MEMBER ELIGIBILITY AND MEDICAL NECESSITY.

Prior Authorization Group – Asthma (non-specific) PA

Drug Name(s):
TEZSPIRE **TEZEPELUMAB-EKKO**

Criteria for approval of Prior Authorization Drug:

1. Prescribed for an approved FDA diagnosis (as listed below):
2. Member does not have any clinically relevant contraindications, or CMS/Plan exclusions, to the requested drug.

- If the member meets all these criteria, they may be approved by the Plan for the requested drug.
- Quantity limits and Tiering will be determined by the Plan.

Exclusion Criteria:
N/A

Prescriber Restrictions:
N/A

Coverage Duration:
Approval will be for 12 months

FDA Indications:
Tezspire

- Asthma (Severe), Add-on maintenance therapy

Off-Label Uses:
N/A

Age Restrictions:

- 12 years or older

Other Clinical Considerations:
N/A

Resources:
https://www.micromedexsolutions.com/micromedex2/librarian/CS/CBB324/ND_PR/evidencexpert/ND_P/evidencexpert/DUPLICATIONSHIELDSYNC/CBBD24/ND_PG/evidencexpert/ND_B/evidencexpert/ND_AppProduct/evidencexpert/ND_T/evidencexpert/PFActionId/evidencexpert.GoToDashboard?docId=933496&contentSetId=100&title=Tezepelumab-ekko&servicesTitle=Tezepelumab-ekko&brandName=Tezspire&UserMdxSearchTerm=Tezspire&=null#