



Tezspire Prior Authorization Request

Your patient's benefit plan requires prior authorization for certain medications. In order to make appropriate medical necessity determinations, your patient's diagnosis and other clinical information is required. **Please complete the information requested on the form below and fax this form along with supporting clinical documentation to Priority Partners, toll-free at 1-866-212-4756 to initiate the review process.** If you have questions regarding the prior authorization please contact Priority Partners at 888-819-1043 Option 4.

Patient's Name: _____ **Date:** _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Referring Provider Info: Same as Requesting Provider

Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Rendering Provider Info: Same as Referring Provider Same as Requesting Provider

Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Required Demographic Information:

Patient Weight: _____ kg

Patient Height: _____ cm

Please indicate the place of service for the requested drug:

- Ambulatory Surgical (POS Code 24) Home (POS Code 12)
 Off Campus Outpatient Hospital (POS Code 19) On Campus Outpatient Hospital (POS Code 22)
 Office (POS Code 11)

Drug Information:

Strength/Measure _____ *Units* ml Gm mg ea Un
Directions(sig) _____ *Route of administration* _____
Dosing frequency _____

Criteria Questions:

What is the ICD-10 code? _____

1. Will the requested drug be used concomitantly with any other biologic (e.g., Adbry, Humira, Dupixent), or targeted synthetic drug (e.g., Rinvoq, Olumiant, Otezla, Xeljanz) for the same indication?

- Yes, *Continue to 2*
 No, *Continue to 2*

2. What is the diagnosis?

- Asthma, *Continue to 3*
 Other, please specify: _____, *Continue to 3*

Send completed form to: Priority Partners Fax: 1-866-212-4756

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Tezspire SGM 5104-A – 09/2023.

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3. Is Tezspire prescribed by or in consultation with an allergist/immunologist or pulmonologist?

Yes, *Continue to 4*

No, *Continue to 5*

4. Is the patient 12 years of age or older?

Yes, *Continue to 5*

No, *Continue to 5*

5. Is this request for continuation of therapy with Tezspire?

Yes, *Continue to 6*

No, *Continue to 11*

6. Is the patient currently receiving Tezspire through samples or a manufacturer's patient assistance program?

Yes, *Continue to 10*

No, *Continue to 7*

Unknown, *Continue to 10*

7. Has asthma control improved on Tezspire treatment as demonstrated by a reduction in the frequency and/or severity of symptoms and exacerbations? **ACTION REQUIRED:** If Yes, please attach supporting chart notes or medical record documentation of improved asthma control. **ACTION REQUIRED:** Submit supporting documentation

Yes, *Continue to 9*

No, *Continue to 8*

8. Has asthma control improved on Tezspire treatment as demonstrated by a reduction in the daily maintenance oral corticosteroid dose? **ACTION REQUIRED:** If Yes, please attach supporting chart notes or medical record documentation of improved asthma control. **ACTION REQUIRED:** Submit supporting documentation

Yes, *Continue to 9*

No, *Continue to 9*

9. Will the patient continue to use maintenance asthma treatments (e.g., inhaled corticosteroid, additional controller) in combination with Tezspire?

Yes, *No Further Questions*

No, *No Further Questions*

10. Has the patient previously received another biologic drug (e.g., Dupixent, Nucala) indicated for asthma? **ACTION REQUIRED:** If Yes, please attach supporting chart notes, medical records, or claims history of previous biologic drug tried including drug, dose, frequency, and duration. **ACTION REQUIRED:** Submit supporting documentation

Yes, *No Further Questions*

No, *Continue to 11*

11. Does the patient have uncontrolled asthma as demonstrated by experiencing two or more asthma exacerbations requiring oral or injectable corticosteroid treatment within the past year? **ACTION REQUIRED:** If Yes, please submit supporting chart notes, medical records, or claims history of previous corticosteroid use for asthma exacerbations including drug, dose, frequency, and duration. **ACTION REQUIRED:** Submit supporting documentation

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- Yes, *Continue to 14*
- No, *Continue to 12*

12. Does the patient have uncontrolled asthma as demonstrated by experiencing one or more asthma exacerbation resulting in hospitalization or emergency medical care visit within the past year? ***ACTION REQUIRED:*** If Yes, please submit supporting chart notes, medical records of previous asthma exacerbations requiring hospitalization or emergency medical visit. ***ACTION REQUIRED:*** Submit supporting documentation

- Yes, *Continue to 14*
- No, *Continue to 13*

13. Does the patient have uncontrolled asthma as demonstrated by experiencing poor symptom control (frequent symptoms or reliever use, activity limited by asthma, night waking due to asthma) within the past year? ***ACTION REQUIRED:*** If Yes, please submit supporting chart notes or medical records. ***ACTION REQUIRED:*** Submit supporting documentation

- Yes, *Continue to 14*
- No, *Continue to 14*

14. Prior to requesting Tezspire, did the patient have inadequate asthma control despite current treatment with both of the following medications at optimized doses: A) High dose inhaled corticosteroid AND B) Additional controller (i.e., long acting beta2-agonist, long acting muscarinic antagonist, leukotriene modifier, or sustained-release theophylline)? ***ACTION REQUIRED:*** If Yes, please attach supporting chart notes, medical records, or claims history of previous medications tried including drug, dose, frequency, and duration. ***ACTION REQUIRED:*** Submit supporting documentation

- Yes, *Continue to 15*
- No, *Continue to 15*

15. Will the patient continue to use maintenance asthma treatments (e.g., inhaled corticosteroid, additional controller) in combination with Tezspire?

- Yes, *No Further Questions*
- No, *No Further Questions*

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by Priority Partners.

X _____

Prescriber or Authorized Signature

Date (mm/dd/yy)

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