OKLAHOMA Health Care Authority

State of Oklahoma
SoonerCare

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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 ≥ 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: _____

Fax completed prior authorization request form to 888-601-8461 or submit Electronic Prior Authorization throughCoverMyMeds® or SureScripts. All requested data must be provided. Incomplete forms or forms without the chart notes will be returned. Pharmacy Coverage Guidelines are available at AetnaBetterHealth.com/Oklahoma.

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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: _____

_____

_____

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.

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