

**AETNA BETTER HEALTH® OF VIRGINIA REQUEST FORM**

**Tezspire® (tezepelumab-ekko)**

**Fax back to: 1-855-799-2553**

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

**MEMBER INFORMATION**

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Last Name:

First Name:

Medicaid ID Number:

Date of Birth:

Weight in Kilograms: \_\_\_\_\_

**PRESCRIBER INFORMATION**

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Last Name:

First Name:

NPI Number:

Phone Number:

Fax Number:

**DRUG INFORMATION**

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Drug Name/Form: \_\_\_\_\_

Strength: \_\_\_\_\_

Dosing Frequency: \_\_\_\_\_

Length of Therapy: \_\_\_\_\_

Quantity per Day: \_\_\_\_\_

The Virginia Department of Medical Assistance Services considers the use of concomitant therapy with Cinqair®, Dupixent®, Fasentra®, Nucala®, Tezspire™ and Xolair® to be experimental and investigational. Safety and efficacy of these combinations have **NOT** been established and will **NOT** be permitted.

*(Form continued on next page.)*

Member's Last Name:

Member's First Name:

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**DIAGNOSIS AND MEDICAL INFORMATION**

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**For severe\* asthma 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 severe\* asthma? **AND**

Yes       No

3. Will coadministration with another monoclonal antibody be avoided (e.g., 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 (e.g., 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 (FEV<sub>1</sub>)? **AND**

Yes       No

*(Form continued on next page.)*

Member's Last Name:

Member's First Name:

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  $\geq 150$  cells/ $\mu$ 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

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

8. Has the member been assessed for toxicity? **AND**

Yes  No

9. Does the member have improvement in asthma symptoms or asthma exacerbations as evidenced by 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 (FEV<sub>1</sub>)?

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 7 times/week
- SABA use for symptom control occurs several times per day
- Extremely limited normal activities
- Lung function (percent predicted FEV<sub>1</sub>) < 60%
- Exacerbations requiring oral systemic corticosteroids are generally more frequent and intense relative to moderate asthma

(Form continued on next page.)

**Member's Last Name:**

**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:**

10. Is the member 12 years of age or older? **AND**

Yes       No

11. Does the member have a diagnosis of bilateral symptomatic sino-nasal polyposis with symptoms lasting at least 8 weeks? **AND**

Yes       No

12. Will coadministration with another monoclonal antibody be avoided (e.g., omalizumab, mepolizumab, reslizumab, benralizumab, dupilumab)? **AND**

Yes       No

13. Has the member tried and failed an 8-week trial of intranasal corticosteroid therapy? **AND**

Yes       No

14. Will Tezspire be used in combination with intranasal corticosteroids (unless intolerant or contraindicated)? **AND**

Yes       No

15. Has the member tried and failed an adequate trial of the preferred product, Xolair (unless contraindicated or clinically inappropriate)?

Yes       No

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

16. Has the member been assessed for toxicity? **AND**

Yes       No

17. 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 (e.g., nasal polyposis score [NPS], nasal congestion [NC] symptom severity score, sinonasal outcome test-22 [SNOT-22]). **OR**

Yes       No

*(Form continued on next page.)*

**Member's Last Name:**

**Member's First Name:**

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18. 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

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**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.