carolina complete health

Pharmacy Prior Approval Request for Monoclonal Antibodies: Tezspire

Beneficiary Information

1. Beneficiary Last Name: _____ 2. First Name: _____
3. Beneficiary ID #: _____ 4. Beneficiary Date of Birth: _____ 5. Beneficiary Gender: _____

Prescriber Information

6. Prescribing Provider NPI #: _____
7. Requester Contact Information - Name: _____ Phone #: _____ Ext. _____

Drug Information

8. Drug Name: _____ 9. Strength: _____ 10. Quantity Per 30 Days: _____
11. Length of Therapy (in days): ☐ up to 30 Days ☐ 60 Days ☐ 90 Days ☐ 120 Days ☐ 180 Days ☐ 365 Days ☐ Other _____

Clinical Information

Initial Approval:

1. Is the beneficiary age 12 years of age or older? ☐ **Yes** ☐ **No**
2. Does the beneficiary have a diagnosis of severe Asthma with evidence of severe disease? ☐ **Yes** ☐ **No**
3. Does the beneficiary have at least 1 of the following? ☐ **Yes** ☐ **No Please indicate which one(s).**_____
   a. Symptoms throughout the day
   b. Nighttime awakenings, often 7x/week
   c. SABA use for symptom control occurring several times per day
   d. Extremely limited normal activities
   e. Lung function (percent predicted FEV1) < 60%
   f. Exacerbations requiring oral systemic corticosteroids generally more frequent and intense relative to moderate asthma
4. Is Tezspire being used for add-on maintenance treatment for a beneficiary who regularly received BOTH of the following? ☐ **Yes** ☐ **No**
   a. Medium- to high-dose inhaled corticosteroids
   b. An additional controller medication (e.g., long-acting beta agonist, leukotriene modifiers
5. Has the beneficiary had, in the previous year, ≥ 2 exacerbations requiring oral or injectable corticosteroid treatment (in addition to the regular maintenance therapy defined above) **OR** one exacerbation resulting in a hospitalization? ☐ **Yes** ☐ **No**
6. Is there a baseline measurement of ≥ 1 of the following for assessment of clinical status? ☐ **Yes** ☐ **No Please indicate which one(s).**_____
   a. Use of systemic corticosteroids
   b. Use of inhaled corticosteroids
   c. Number of hospitalizations, ER visits, or unscheduled visits to healthcare provider due to condition
   d. FEV1
7. Will the beneficiary use Tezspire for the relief of acute bronchospasm or status asthmaticus? ☐ **Yes** ☐ **No**
8. Will the beneficiary use Tezspire in combination with anti-IgE, anti-IL4, or anti-IL5 monoclonal antibody agents (e.g., benralizumab, omalizumab, mepolizumab, reslizumab, dupilumab)? ☐ **Yes** ☐ **No**
9. Does the beneficiary have hypersensitivity to tezepelumab-ekko (Tezspire) or any of its excipients? ☐ **Yes** ☐ **No**
10. Does the beneficiary have an active or untreated helminth infection? ☐ **Yes** ☐ **No**
11. Will Tezspire be administered concurrently with live vaccines? ☐ **Yes** ☐ **No**

Initial approval can be for up to 6 months

For continuation of therapy, please answer questions 1-13

12. While on Tezspire, has the beneficiary experienced improvement in asthma symptoms, asthma exacerbations, or airway function as evidenced by decrease in ≥ 1 of the following? ☐ **Yes** ☐ **No Please indicate which one(s).**_____
   a. Use of systemic corticosteroids
   b. Two-fold or greater decrease in inhaled corticosteroid use for at least 3 days
   c. Hospitalizations
   d. ER visits
   e. Unscheduled visits to healthcare provider

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f. Improvement from baseline in FEV1

13. Has the beneficiary experienced any serious treatment-related adverse events (e.g., parasitic [helminth] infection, severe hypersensitivity reactions)?

☐ **Yes** ☐ **No**

Reauthorizations can be for up to 6 months

** Please provide medical records documenting the beneficiary's current Asthma status and response to Tezspire treatment**

Signature of Prescriber:_____ Date: _____

(Prescriber Signature Mandatory)

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

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