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Government of District of Columbia Department of Health Care Finance

Tezspire Prior Authorization Request Form

REQUEST DATE: _____

PATIENT INFORMATION

PATIENT MEDICAID ID: _____ **DATE OF BIRTH:** _____

PATIENT LAST NAME: _____

PATIENT FIRST NAME: _____ **MIDDLE INITIAL:** _____

PRESCRIBER INFORMATION

PRESCRIBER LAST NAME: _____

PRESCRIBER FIRST NAME: _____

PRESCRIBER PHONE: _____ **PRESCRIBER FAX:** _____

PRESCRIBER DEA NUMBER: _____ **PRESCRIBER NPI NUMBER:** _____

PHYSICIAN SPECIALTY: _____

DRUG ADMINISTRATION REQUESTED (210 MG): ☐ PEN ☐ PREFILLED SYRINGE

QUANTITY: _____ **DIRECTIONS:** _____

PHARMACY INFORMATION

PHARMACY NAME: _____

PHARMACY PHONE: _____ **PHARMACY FAX:** _____

PHARMACY NPI NUMBER: _____

PRIOR AUTHORIZATION CRITERIA

Tezspire is indicated for the add-on maintenance treatment of adult and pediatric patients 12 years of age and older with severe asthma.

- Is the recipient 12 years of age or older? ☐ Yes ☐ No
- Does the recipient have a diagnosis of severe asthma? ☐ Yes ☐ No
- The recipient has been compliant with an inhaled corticosteroid (ICS) **plus** either a long-acting beta agonist (LABA) **or** another controller agent (e.g., leukotriene receptor antagonist [LTRA]) for at least 3 consecutive months prior to the date of the request [names of medications must be **stated on the request**] ☐ Yes ☐ No

  Names of Medications: _____
- Even with compliant use of a controller regimen, the recipient's asthma continues to be uncontrolled as defined by **one** of the following which is **stated on the request (choose one)**:
  - ☐ The recipient has had two or more asthma exacerbations which required treatment with systemic corticosteroids in the previous 12 months
  - ☐ The recipient has had at least one asthma exacerbation requiring hospitalization in the previous 12 months; **OR**
  - ☐ The recipient has an FEV1 < 80% predicted
- This medication is **not** being used in combination with other monoclonal antibodies used to treat asthma ☐ Yes ☐ No
- This medication **is** being used in combination with an inhaled corticosteroid (ICS) **plus** either a long-acting beta agonist (LABA) **or** another controller agent (e.g., leukotriene receptor antagonist [LTRA]) [names of medications must be **stated on the request**] ☐ Yes ☐ No

  Names of Medications: _____
- By submitting the authorization request, the prescriber attests to the following:
  - The prescribing information for the requested medication has been thoroughly reviewed, including any Black Box warning,), contraindications, minimum age requirements, recommended dosing, and prior treatment requirements; **AND**
  - All laboratory testing and clinical monitoring recommended in the prescribing information have been completed as of the date of the request and will be repeated as recommended; **AND**
  - The recipient has no concomitant drug therapies or disease states that limit the use of the requested medication and will not receive the requested medication in combination with any medication that is contraindicated or not recommended per FDA labeling.

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RENEWAL AUTHORIZATION

- The recipient has met and continues to meet initial approval criteria ☐ Yes ☐ No
- This medication **is** being used in combination with an inhaled corticosteroid (ICS) **plus** either a long-acting beta agonist (LABA) **or** another controller agent (e.g., leukotriene receptor antagonist [LTRA]) [Names of medications must be **stated on the request**] ☐ Yes ☐ No

  Names of Medications: _____
- The prescriber **states on the request** that the recipient is established on the medication with evidence of a positive response to therapy. ☐ Yes ☐ No
- Duration of initial and reauthorization approval: **12 months**

I certify that, to the best of my knowledge, all information I have provided on this request is complete and factual.

PRESCRIBER'S SIGNATURE: _____ **DATE**: _____