IOWA Health and Human Services

Request for Prior Authorization

TEZEPELUMAB-EKKO (TEZSPIRE) PREFILLED PEN

(PLEASE PRINT – ACCURACY IS IMPORTANT)

FAX Completed Form To
1 (800) 574-2515
Provider Help Desk
1 (877) 776-1567

IA Medicaid Member ID #	Patient name	DOB
Patient address		
Provider NPI	Prescriber name	Phone
Prescriber address		Fax
Pharmacy name	Address	Phone
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.		
Pharmacy NPI	Pharmacy fax	NDC

Prior authorization (PA) is required for tezepelumab-ekko (Tezspire) prefilled pen. Requests for tezepelumab-ekko (Tezspire) single dose vial or prefilled syringe will not be considered through the pharmacy benefit. Payment will be considered for an FDA approved or compendia indicated diagnosis for the requested drug when the following conditions are met:

1. **Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and**
2. **Patient has a diagnosis of severe asthma; and**
   a. **Symptoms are inadequately controlled with documentation of current treatment with a high-dose inhaled corticosteroid (ICS) given in combination with a controller medication (e.g., long-acting beta2 agonist [LABA], leukotriene receptor agonist [LTRA], oral theophylline) for a minimum of 3 consecutive months. Patient must be compliant with therapy, based on pharmacy claims; and**
   b. **Patient must have one of the following, in addition to the regular maintenance medications defined above:**
      i. **Two or more asthma exacerbations requiring oral or injectable corticosteroid treatment in the previous 12 months; or**
      ii. **One or more asthma exacerbations resulting in hospitalization in the previous 12 months; and**
   c. **This medication will be used as an add-on maintenance treatment; and**
   d. **Patient/caregiver will administer medication in patient's home; and**
   e. **Is not prescribed in combination with other biologics indicated for asthma; or**
3. **Patient has a diagnosis of inadequately controlled rhinosinusitis with nasal polyps (CRSwNP); and**
   a. **Documentation that tezepelumab will be used as an add-on maintenance treatment; and**
   b. **Documentation of an adequate trial and therapy failure with at least one preferred medication from each of the following categories:**
      i. **Nasal corticosteroid spray; and**
      ii. **Oral corticosteroid**

If criteria for coverage are met, initial authorization will be given for 6 months to assess the response to treatment. Requests for continuation of therapy will require documentation of a positive response to therapy.

The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

Preferred

☐ Tezspire Prefilled Pen

Strength_____ **Dosage Instructions**_____ **Quantity**_____ **Days Supply**_____

Diagnosis:_____

☐ **Severe Asthma**

Document current treatment with a high-dose ICS given in combination with a controller medication:

Request for Prior Authorization

TEZEPELUMAB-EKKO
(TEZSPIRE)
PREFILLED PEN

(PLEASE PRINT – ACCURACY IS IMPORTANT)

High-Dose ICS Trial:

Drug name & dose:_____ Trial dates:_____

Failure reason:_____

Controller Medication Trial:
Drug name & dose:_____ Trial dates:_____

Failure reason:_____

Does patient have one of the following?

Two (2) or more asthma exacerbations requiring oral or injectable corticosteroid treatment in the previous 12 months?
☐ Yes ☐ No

One or more asthma exacerbations resulting in hospitalization in the previous 12 months? ☐ Yes ☐ No

Will this medication be used as an add-on maintenance treatment? ☐ Yes ☐ No

Will medication be administered in patient's home? ☐ Yes ☐ No

Will medication be prescribed in combination with other biologics? ☐ Yes ☐ No

☐ **CRSwNP**

Will this medication be used as an add-on maintenance treatment? ☐ Yes ☐ No

Nasal Corticosteroid Spray Trial:

Drug name & dose:_____ Trial dates:_____

Failure reason:_____

Oral Corticosteroid Trial:

Drug name & dose:_____ Trial dates:_____

Failure reason:_____

Renewals:

Document positive response to therapy:_____

Medical or contraindication reason to override trial requirements:_____

Attach lab results and other documentation as necessary.

Prescriber signature (Must match prescriber listed above.)	Date of submission

IMPORTANT NOTE: *In evaluating requests for prior authorization, the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary, by contact with the county Department of Health and Human Services, that the member continues to be eligible for Medicaid.*