

AvMed

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff; **fax to 1-305-671-0200**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: Tezspire™ (tezepelumab) (Pharmacy)

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member AvMed #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ Length of Therapy: _____

Diagnosis: _____ ICD Code, if applicable: _____

Weight (if applicable): _____ Date weight obtained: _____

Recommended Dosage: Adults and adolescents ≥ 12 years: 210 mg/1.9 mL SubQ, single-dose prefilled syringe or single dose vial once every 4 weeks

*The Health Plan considers the use of concomitant therapy with Cinqair®, Dupixent®, Fasenra®, Nucala®, Tezspire™ and Xolair® to be experimental and investigational. Safety and efficacy of these combinations have **NOT** been established and will **NOT** be permitted. In the event a member has an active Cinqair®, Dupixent®, Fasenra®, Nucala®, and Xolair® authorization on file, all subsequent requests for Tezspire™ will **NOT** be approved.

Medication will be (select **ONE** of the following):

- ☐ Self-Administered (pharmacy benefit)
- ☐ Administered by Provider (medical benefit)

(Continued on next page)

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

Initial Authorization: 12 months

- ☐ Member has a confirmed diagnosis of severe asthma
- ☐ Prescribed by or in consultation with an allergist, immunologist or pulmonologist
- ☐ Member is 12 years of age or older
- ☐ Has the member been approved for Tezspire™ previously through the Health Plan medical department?
☐ Yes ☐ No
- ☐ Member is currently being treated with **ONE** of the following unless there is a contraindication or intolerance to these medications and must be compliant on therapy **for at least 90 consecutive days** within a year of request (**verified by pharmacy paid claims**):
 - ☐ High-dose inhaled corticosteroid (ICS) (e.g., greater than 500 mcg fluticasone propionate equivalent/day) **AND** an additional asthma controller medication (e.g., leukotriene receptor antagonist, long-acting beta-2 agonist (LABA), theophylline)
 - ☐ One maximally dosed combination ICS/LABA product (e.g., Advair® (fluticasone propionate/salmeterol), Dulera® (mometasone/formoterol), Symbicort® (budesonide/formoterol))
- ☐ Member has experienced **ONE** of the following (check box that applies):
 - ☐ **ONE (1)** or more exacerbations requiring additional medical treatment (e.g., oral corticosteroids, emergency department, urgent care visits or hospitalizations within the past 12 months)
 - ☐ Any prior intubation for an asthma exacerbation
- ☐ Member has a baseline forced expiratory volume (FEV1) < 80% predicted normal (< 90% for members 12-17 years old) submitted with the year of request

Reauthorization: 12 months. Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

- ☐ Member has experienced a sustained positive clinical response to Tezspire™ therapy as demonstrated by at least **ONE** of the following (**check all that apply**):
 - ☐ Increase in percent predicted Forced Expiratory Volume (FEV1) from baseline (pre-treatment)
 - ☐ Reduction in the dose of inhaled corticosteroids required to control asthma
 - ☐ Reduction in the use of oral corticosteroids to treat/prevent exacerbation
 - ☐ Reduction in asthma symptoms such as chest tightness, coughing, shortness of breath or nocturnal awakenings

(Continued on next page)

- ❑ Member is currently being treated with **ONE** of the following unless there is a contraindication or intolerance to these medications (**verified by pharmacy paid claims**):
 - ❑ High-dose inhaled corticosteroid (ICS) (e.g., greater than 500 mcg fluticasone propionate equivalent/day) **AND** an additional asthma controller medication (e.g., leukotriene receptor antagonist, long-acting beta-2 agonist (LABA), theophylline)
 - ❑ One maximally dosed combination ICS/LABA product (e.g., Advair[®] (fluticasone propionate/salmeterol), Dulera[®] (mometasone/formoterol), Symbicort[®] (budesonide/formoterol))

Medication being provided by a Specialty Pharmacy – Proprium Rx
--

*****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.*****

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****