Tezspire (tezepelumab)
Prior Authorization Request Form

Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

☐ **URGENT**

MEMBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PHONE NUMBER:	**DATE OF BIRTH:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
PATIENT INSURANCE ID NUMBER:	

☐ **MALE** ☐ **FEMALE** **HEIGHT (IN/CM):** _____ **WEIGHT (LB/KG):** _____ **ALLERGIES:** _____

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: PRIMETHERAPEUTICS.COM/NOPP

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): _____

AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: _____

PRESCRIBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PRESCRIBER SPECIALTY:	**EMAIL ADDRESS:**
NPI NUMBER:	**DEA NUMBER:**
PHONE NUMBER:	**FAX NUMBER:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
REQUESTOR (if different than prescriber)**:**	**OFFICE CONTACT PERSON:**

MEDICATION OR MEDICAL DISPENSING INFORMATION			
MEDICATION NAME:			
DOSE/STRENGTH:	**FREQUENCY:**	**LENGTH OF THERAPY/REFILLS:**	**QUANTITY:**
☐ **NEW THERAPY** ☐ **RENEWAL**		**IF RENEWAL:** DATE THERAPY INITIATED:	
DURATION OF THERAPY (SPECIFIC DATES):			

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MEMBER'S LAST NAME: _____ **MEMBER'S FIRST NAME:** _____

1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? ☐ YES (if yes, complete below) ☐ NO		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE)**:**	**DURATION OF THERAPY** (SPECIFY DATES)**:**	**RESPONSE/REASON FOR FAILURE/ALLERGY:**

2. LIST DIAGNOSES:	**ICD-10:**
□ Moderate to severe asthma □ Chronic rhinosinusitis with nasal polyps(CRSwNP) □ Other diagnosis: _____ICD-10:_____	

3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.

Clinical Information:

Will Tezspire be used as part of a clinical trial? □ Yes □ No

Is the prescriber one of the following or in consultation with one of the following?
☐ Yes ☐ No (Please provide documentation)
□ Allergist
□ Immunologist
□ Dermatologist
□ Pulmonologist
□ Otolaryngologist

Is patient receiving Xolair in combination with any of the following? ☐ Yes ☐ No
□ Anti-interleukin 4 therapy [e.g., Dupixent (dupilumab)]
□ Anti-interleukin 5 therapy [e.g., Nucala (mepolizumab), Cinqair (resilizumab), Fasenra (benralizumab)]
□ Anti-interleukin 31 therapy[e.g. Nemluvio(nemolizumab-ilto)
□ Anti-IgE antibody[Xolair(omalizumab/Omlyclo(omalizumab-igce)]

<u>Initial Request For diagnosis of moderate to severe asthma, please answer the following:</u>

Will Tezspire be used for add-on maintenance treatment in patient receiving both a medium to high-dose inhaled corticosteroid and a an additional controlled medication? □ Yes □ No

Was the patient treated with medium or high dose inhaled corticosteroid for at least 12 months? □ Yes □ No

Was the patient treated with a total daily dose of either medium or high dose ICS (at least 500 micrograms of fluticasone) for at least 3-months? □ Yes □ No

For adults (18 years of age and older), does the patient have an FEV_1 equaling less than 80% of the predicted volume? □ Yes □ No Please submit chart notes/PFT report

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For adolescents (age 12-17 years), does the patient have an FEV_1 equaling less than 90% of the predicted volume? □ Yes □ No Please submit chart notes/PFT report

Has the patient 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? □ Yes □ No

Does the patient have COPD or other concurrent lung diseases? □ Yes □ No

Is the patient a current smoker? □ Yes □ No

Is the patient a former smoker with a smoking history of more than 10 pack-years? □ Yes □ No

Initial Request for Chronic rhinosinusitis with nasal polyps (CRSwNP):

Does patient have a diagnosis of chronic rhinosinusitis with nasal polyps (CRSwNP)? ☐ Yes ☐ No (Please provide documentation)

Has patient been unable to obtain symptom relief after trial of an Intranasal corticosteroids (e.g., fluticasone, mometasone, triamcinolone)? ☐ Yes ☐ No (Please provide documentation)

Has patient been unable to obtain symptom relief after trial of one other therapy used in the management of nasal polyps [i.e., nasal saline irrigations. antileukotriene agents (e.g., montelukast, zafirlukast, zileuton)]? ☐ Yes ☐ No (Please provide documentation)

Has patient required systemic corticosteroids (e.g., prednisone, methylprednisolone) for CRSwNP in the previous 2 years? ☐ Yes ☐ No (Please provide documentation)

Has patient required prior sinus surgery? ☐ Yes ☐ No (Please provide documentation)

Will patient receive Xolair as add-on maintenance therapy in combination with intranasal corticosteroids (e.g., fluticasone, mometasone, triamcinolone)? ☐ Yes ☐ No

For new starts only, has patient had a 3-month trial of Dupixent (dupilumab)? ☐ Yes ☐ No (Please provide documentation)

Does patient have an absolute contraindication to Dupixent (dupilumab)? ☐ Yes ☐ No (Please provide documentation)

Renewal Request:

Has patient demonstrated a reduction in severity of their disease/symptoms? ☐ Yes ☐ No (Please provide documentation)

Is patient continuing to have clinical disease? ☐ Yes ☐ No (Please provide documentation)

Is patient receiving Xolair in combination with any of the following? ☐ Yes ☐ No
□ Anti-interleukin 4 therapy [e.g., Dupixent (dupilumab)]

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□ **Anti-interleukin 5 therapy [e.g., Nucala (mepolizumab), Cinqair (resilizumab), Fasenra (benralizumab)]**
□ **Anti-interleukin 31 therapy [e.g. Nemluvio(nemolizumab-ilto)**
□ **Anti-IgE antibody[Xolair(omalizumab/Omlyclo)]**

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received.

ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature or Electronic I.D. Verification: _____ Date: _____

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FAX THIS FORM TO: 800-424-7640
MAIL REQUESTS TO: Prime Therapeutics Management Prior Authorization Program
Attn: CP – 4201
P.O. Box 64811
St. Paul, MN 55164-0811

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