SENTARA HEALTH PLANS

MEDICAL 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 1-844-668-1550**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If information provided is not complete, correct, or legible, authorization can be delayed**.

For Medicare Members: Medicare Coverage for outpatient (Part B) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals. In addition, National Coverage Determination (NCD) and Local Coverage Determinations (LCDs) may exist and compliance with these policies is required where applicable. They can be found at: https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx. Additional indications may be covered at the discretion of the health plan.

Drug Requested: Tezspire® (tezepelumab) **(J2356) (Medical)**

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

Member Name: _____

Member Sentara #: _____ **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:** _____

❑ Standard Review. In checking this box, the timeframe does not jeopardize the life or health of the member or the member's ability to regain maximum function and would not subject the member to severe pain.

Recommended Dosage: Adults and adolescents ≥ 12 years: 210 mg administered subcutaneously 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.**

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Medication will be (select ONE of the following):

- ❑ **Self-Administered** (pharmacy benefit)
- ❑ **Administered by Provider** (medical benefit)

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.

❑ **Diagnosis: Severe Asthma**

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 pharmacy 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

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❑ Diagnosis: Severe Asthma

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
- ❑ 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))

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.

❑ Diagnosis: Chronic Rhinosinusitis with Nasal Polyps (CRSwNP)

Initial Authorization: 12 months

- ❑ Prescribed by or in consultation with an allergist, immunologist or otolaryngologist
- ❑ Member is 12 years of age or older
- ❑ Has the member been approved for Tezspire™ previously through the Health Plan pharmacy department?
  - ❑ Yes ❑ No
- ❑ Member has a **diagnosis of CRSwNP** confirmed by the American Academy of Otolaryngology-Head and Neck Surgery Clinical Practice Guideline (Update): Adult Sinusitis (AAO-HNSF 2015)/American Academy of Allergy Asthma & Immunology (AAAAI) with **ONE** of the following clinical procedures:
  - ❑ Anterior rhinoscopy
  - ❑ Nasal endoscopy
  - ❑ Computed tomography (CT)

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- ❑ Member has a documented diagnosis of chronic rhinosinusitis defined by at least 12 weeks of the following:
  - ❑ Mucosal inflammation **AND** at least **TWO** of the following:
    - ❑ Decreased sense of smell
    - ❑ Facial pressure, pain, fullness
    - ❑ Mucopurulent drainage
    - ❑ Nasal obstruction
- ❑ Member has tried and failed intranasal corticosteroids **for at least 30 consecutive days** within a year of request **(verified by pharmacy paid claims)**
- ❑ Member is requesting Tezspire® (tezepelumab) as add-on therapy to maintenance intranasal corticosteroids **(verified by pharmacy paid claims)**

❑ Diagnosis: Chronic Rhinosinusitis with Nasal Polyps (CRSwNP)

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 positive clinical response to Tezspire® therapy (e.g., reduced nasal polyp size, improved nasal congestion, reduced sinus opacification, decreased sino-nasal symptoms, improved sense of smell, reduction in use of oral corticosteroids)
- ❑ Member has been compliant with Tezspire® therapy and continues to receive therapy with an intranasal corticosteroid **(verified by pharmacy paid claims)**

❑ Medication being provided by (check applicable box(es) below):

❑ **Physician's office** **OR** ❑ **Specialty Pharmacy**

For urgent reviews: Practitioner should call Sentara Health Plans Pre-Authorization Department if they believe a standard review would subject the member to adverse health consequences. Sentara Health Plan's definition of urgent is a lack of treatment that could seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

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.

***Approved by Pharmacy and Therapeutics Committee:** ~~3/17/2022, 7/24/2025,~~ **11/20/2025**
REVISED/UPDATED/REFORMATTED: ~~3/30/2022, 6/27/2022, 8/5/2025,~~ **12/11/2025**