# SENTARA COMMUNITY PLAN
# (MEDICAID)

## 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 1-800-750-9692**. 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) (Non-Preferred)**

**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 Name/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

***Sentara Health Plans considers the use of concomitant therapy with Cinqair®, Dupixent®, Fasenra®, Nucala®, 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.**

**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.

Has the member been approved for Tezspire™ previously through the Sentara medical department?

❑ Yes ❑ No

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## ❑ DIAGNOSIS: Severe Asthma*

**Initial Authorization: 6 months**

1. Is the member 12 years of age or older?
   ❑ Yes ❑ No
2. Does the member have a diagnosis of severe asthma*?
   ❑ Yes ❑ No
3. Will coadministration with another monoclonal antibody be avoided (i.e. omalizumab, mepolizumab, reslizumab, benralizumab, and dupilumab)?
   ❑ Yes ❑ No
4. Will Tezspire™ be used for add-on maintenance treatment in members regularly receiving both (unless otherwise contraindicated) of the following:
   - Medium to high dose inhaled corticosteroids **AND**
   - An additional controller medication (i.e. long-acting beta agonist, leukotriene modifiers?

   ❑ Yes ❑ No
5. Has the member 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 hospitalization?
   ❑ Yes ❑ No
6. Does the member have at least one of the following for assessment of clinical status:
   - Use of systemic corticosteroids
   - Use of inhaled corticosteroids
   - Number of hospitalizations, ER visits, or unscheduled visits to healthcare provider due to condition
   - Forced expiratory volume in 1 second ($FEV_1$)?

   ❑ Yes ❑ No
7. Has the member tried and failed an adequate trial of the 2 different preferred products (Fasenra® and Xolair®)?
   ❑ Yes ❑ No ❑ N/A (continued below)

   If N/A selected for question 7, please answer the following:
   1. Does the member lack an eosinophilic phenotype with blood eosinophils ≥ 150 cells/µL? **AND**
      ❑ Yes ❑ No
   2. Does the member have a serum IgE level < 30 IU/mL? **OR**
      ❑ Yes ❑ No
   3. Does the member have another predicted intolerance to the preferred agents?
      ❑ Yes ❑ No

      Please provide explanation: _____

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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.

1. Has the member been assessed for toxicity?
   ❑ Yes ❑ No
2. Does the member have improvement in asthma symptoms or asthma exacerbations as evidenced by a decrease in one or more of the following:
   - Use of systemic corticosteroids
   - Hospitalizations
   - ER visits
   - Unscheduled visits to healthcare provider
   - Improvement from baseline in forced expiratory volume in 1 second ($FEV_1$)?

   ❑ Yes ❑ No

***Components of severity for classifying asthma as severe may include any of the following (not all inclusive):**

- Asthma that remains uncontrolled despite optimized treatment with high-dose ICS-LABA
- Asthma that requires high-dose ICS-LABA to prevent it from being uncontrolled
- Symptoms throughout the day
- Nighttime awakenings, often 7 times per week
- SABA use for symptom control occurs several times per day
- Extremely limited normal activities
- Lung function (percent predicted $FEV_1$) < 60%
- Exacerbations requiring oral systemic corticosteroids are generally more frequent and intense relative to moderate asthma

## ❑ DIAGNOSIS: Chronic rhinosinusitis with nasal polyps (CRSwNP)

**Initial Authorization: 6 months**

1. Is the member 12 years of age or older?
   ❑ Yes ❑ No
2. Does the member have a diagnosis of bilateral symptomatic sino-nasal polyposis with symptoms lasting at least 8 weeks?
   ❑ Yes ❑ No
3. Will coadministration with another monoclonal antibody be avoided (e.g. omalizumab, mepolizumab, reslizumab, benralizumab, dupilumab)?
   ❑ Yes ❑ No

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4. Has the member tried and failed an 8-week trial of intranasal corticosteroid therapy?
   ❑ Yes ❑ No
5. Will Tezspire be used in combination with intranasal corticosteroids (unless intolerant or contraindicated)?
   ❑ Yes ❑ No
6. Has the member tried and failed an adequate trial of the preferred product, Xolair (unless contraindicated or clinically inappropriate)?
   ❑ Yes ❑ No

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**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.

1. Has the member been assessed for toxicity?
   ❑ Yes ❑ No
2. Has the member experienced a disease response as indicated by improvement in signs and symptoms compared to baseline in one or more of the following: nasal/obstruction symptoms, improvement of sinus opacifications as assessed by CT-scans and/or an improvement on a disease activity scoring tool (e.g., nasal polyposis score [NPS], nasal congestion [NC] symptom severity score, sinonasal outcome test-22 [SNOT-22]). **OR**
   ❑ Yes ❑ No
3. Did the member have improvement in at least one of the following response criteria:
   ❑ Reduction in nasal polyp size
   ❑ Reduction in need for systemic corticosteroids
   ❑ Improvement in quality of life
   ❑ Improvement in sense of smell
   ❑ Reduction of impact of comorbidities

## Medication being provided by Specialty Pharmacy - PropriumRx

***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.***



**REVISED/UPDATED/REFORMATTED:** ~~3/30/2022; 6/16/2022 11/10/2023, 5/28/2024; 6/11/2024; 6/20/2025;~~ **12/14/2025**