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.

Initial Authorization: 6 months

(Continued on next page)

1. Has the member been approved for Tezspire™ previously through the Sentara medical department?
   ❑ Yes ❑ No
2. Is the member 12 years of age or older?
   ❑ Yes ❑ No
3. Does the member have a diagnosis of severe asthma*?
   ❑ Yes ❑ No
4. Will coadministration with another monoclonal antibody be avoided (i.e. omalizumab, mepolizumab, reslizumab, benralizumab, and dupilumab)?
   ❑ Yes ❑ No
5. 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
6. 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
7. 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
8. 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 8, 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: _____

(Continued on next page)

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

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.****