HIGHMARK WHOLECARE

Updated: 2/2022
PARP Approved: 3/2022

Prior Authorization Criteria

Tezspire (tezepelumab)

All requests for Tezspire (tezepelumab) require a prior authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Coverage may be provided with a diagnosis of **severe asthma** and the following criteria is met:

- Must be prescribed by, or in consultation with, an allergist, immunologist, or pulmonologist
- Is age-appropriate according to FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature
- The requested dose and frequency is in accordance with FDA-approved labeling, nationally recognized compendia, and/or evidence-based practice guidelines
- For non-preferred or non-formulary agents, the member has had a trial and failure of a preferred agent or submitted a clinical reason for not having a trial of a preferred agent
- Must have a pre-bronchodilator FEV1 < 80% for adults OR < 90% for adolescents
- Must have ONE of the following:
    - Required systemic (oral or parenteral) corticosteroids to control asthma exacerbations ≥ 2 times in the past year
    - Required hospitalization due to an asthma exacerbation within the past year
- Symptoms have been uncontrolled despite adherence with at least a three month trial of controller medications consisting of **BOTH** of the following:
    - An inhaled corticosteroid
    - Another asthma controller medication (e.g. long-acting beta agonist, leukotriene receptor antagonist, theophylline)
- The requested medication will be used in conjunction with **ONE** of the following:
    - A maximally-dosed combination inhaled corticosteroid/long-acting-beta-agonist product **OR**
    - Combination therapy consisting of **BOTH** of the following:
        - A maximally-dosed inhaled corticosteroid
        - An additional standard asthma controller medication (e.g., long-acting beta agonist, leukotriene receptor antagonist, etc.)
- **Initial Duration of Approval:** 6 months
- **Reauthorization criteria**
    - Documentation the member had a positive clinical response or stabilization as demonstrated by one of the following:
        - An increase in the member's FEV_1
        - A decreased need for systemic corticosteroids
        - A decrease in the number of asthma related hospitalizations
        - A reduction in reported asthma-related symptoms
    - Continues to use the requested medication in addition to standard asthma controller medications as recommended by current national treatment guidelines for the diagnosis and management of asthma (e.g. inhaled corticosteroids, long-acting beta-2 agonist, leukotriene receptor antagonist, theophylline)
- **Reauthorization Duration of approval:**12 months

Coverage may be provided for any non-FDA labeled indication if it is determined that the use is a medically accepted indication supported by nationally recognized pharmacy compendia or peer-reviewed medical literature for treatment of the diagnosis(es) for which it is prescribed. These requests will be reviewed on a case by case basis to determine medical necessity.

When criteria are not met, the request will be forwarded to a Medical Director for review. The physician reviewer must override criteria when, in their professional judgment, the requested medication is medically necessary.

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TEZSPIRE (TEZEPELUMAB)
PRIOR AUTHORIZATION FORM – PAGE 1 of 2

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Highmark Wholecare Pharmacy Services. **FAX:** (888) 245-2049
If needed, you may call to speak to a Pharmacy Services Representative. **PHONE**: (800) 392-1147 Mon – Fri 8:30am to 5:00pm

PROVIDER INFORMATION

Requesting Provider:	Provider NPI:
Provider Specialty:	Office Contact:
State license #:	Office NPI:
Office Address:	Office Phone:
	Office Fax:

MEMBER INFORMATION

Member Name:	DOB:	
Member ID:	Member weight:	Height:

REQUESTED DRUG INFORMATION

Medication:	Strength:	
Directions:	Quantity:	Refills:
Is the member currently receiving requested medication? ☐ Yes ☐ No	Date Medication Initiated:	

Billing Information

This medication will be billed: ☐ at a pharmacy **OR** ☐ medically, JCODE:_____

Place of Service: ☐ Hospital ☐ Provider's office ☐ Member's home ☐ Other

Place of Service Information

Name:	NPI:
Address:	Phone:

MEDICAL HISTORY (Complete for ALL requests)

Diagnosis:	ICD Code:

What is the severity of the asthma? ☐ Mild ☐ Moderate ☐ Severe
What is the FEV1: ☐ < 80% ☐ 80-89% ☐ ≥ 90%
How many times in the past year have systemic corticosteroids been required? ☐ None ☐ 1 ☐ ≥ 2
Have they been hospitalized for an asthma exacerbation in the past year? ☐ Yes ☐ No
What is the current therapy? Check all that apply:
☐ Inhaled corticosteroid ☐ Long-acting beta-agonist (LABA)
☐ Leukotriene modifier ☐ Other (e.g. tiotropium, theophylline): _____
What will this medication be used with? Please check all that apply.
☐ Combination inhaled corticosteroid/long-acting-beta-agonist
☐ Inhaled corticosteroid
☐ Standard asthma controller medication (e.g. long-acting beta agonist, leukotriene receptor agonist)

CURRENT and PREVIOUS THERAPY

Medication Name	Strength/ Frequency	Dates of Therapy	Status (Discontinued & Why/Current)

TEZSPIRE (TEZEPELUMAB)
PRIOR AUTHORIZATION FORM (CONTINUED)– PAGE 2 of 2

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MEMBER INFORMATION

Member Name:	DOB:	
Member ID:	Member weight:	Height:

REAUTHORIZATION

What has been experienced since starting treatment? Check all that apply.

- ☐ Increase in FEV1
- ☐ Decreased need for systemic corticosteroids
- ☐ Decrease in asthma related hospitalizations
- ☐ Reduction in asthma-related symptoms

What is this medication be used with? Please check all that apply.

- ☐ Combination inhaled corticosteroid/long-acting-beta-agonist
- ☐ Inhaled corticosteroid
- ☐ Standard asthma controller medication (e.g. long-acting beta agonist, leukotriene receptor agonist)

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature	Date