Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
Tezspire (tezepelumab-ekko) Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk
Length of Authorizations: Initial- 6 months; Continuation- 12 months

Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **Tezspire (tezepelumab-ekko).** Please complete and fax this form back to Kaiser Permanente within 24 hours [fax: 1-866-331-2104]. If you have any questions or concerns, please call 1-866-331-2103. **Requests will not be considered unless all sections are complete.**

KP-MAS Formulary can be found at: Pharmacy | Community Provider Portal | Kaiser Permanente

1 – Patient Information

Patient Name: _____ Kaiser Medical ID#: _____ Date of Birth: _____

2 – Prescriber Information

Prescriber Name: _____ Specialty: _____ NPI: _____

Prescriber Address: _____

Prescriber Phone #: _____Prescriber Fax #: _____

3 – Pharmacy Information

Pharmacy Name: _____ Pharmacy NPI: _____

Pharmacy Phone #_____ Pharmacy Fax #: _____

4 – Drug Therapy Requested

Drug 1: Name/Strength/Formulation: _____
Sig: _____

Drug 2: Name/Strength/Formulation: _____
Sig: _____

Note: The Virginia Department of Medical Assistance Services 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 approved

(Form continued on next page)

5– Diagnosis/Clinical Criteria

1. Is this request for initial or continuing therapy?

□ Initial therapy □ Continuing therapy, state start date: _____

2. Does the member have a diagnosis of *severe asthma?

□ No □ Yes

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

- Asthma remains uncontrolled despite optimized treatment with high-dose ICS-LABA
- Asthma requires high-dose ICS-LABA to prevent it from being uncontrolled
- Symptoms throughout the day
- Nighttime awakenings, often 7 times/week
- SABA use for symptom control occurs several times per day
- Extremely limited normal activities
- Lung function (percent predicted FEV1) < 60%

Exacerbations requiring oral systemic corticosteroids are generally more frequent and intensely relative to moderate asthma

Clinical Criteria:

1. Member is ≥ 12 years of age

□ No □ Yes

2. Will coadministration with another monoclonal antibody be avoided (e.g., omalizumab, mepolizumab, reslizumab, benralizumab, dupilumab)? **AND**

□ No □ Yes

3. Is this being used as an 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 (e.g., long-acting beta agonist, leukotriene modifiers)?

□ No □ Yes

4. 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 a hospitalization? **AND**

□ No □ Yes

5. 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 (e.g., ER visits, or unscheduled visits to healthcare providers due to condition)
    - Forced expiratory volume in 1 second (FEV_1)? **AND**

□ No □ Yes

6. Has the member tried and failed an adequate trial of the 2 different preferred products (Fasenra® and Xolair®)?

□ No □ Yes □ N/A (continued below)

If **N/A** was selected for question 6 please answer the following:

a. Does the member lack an eosinophilic phenotype with blood eosinophils ≥150 cells/µL? **AND**

□ No □ Yes

b. Does the member have a serum IgE level < 30 IU/mL? **OR**

□ No □ Yes

c. Does the member have another predicted intolerance to the preferred agent? (Answer below)

□ No □ Yes

_____

For continuation of *severe asthma therapy, please respond to <u>additional questions</u> below to receive 12-month approval:

1. Has the member been assessed for toxicity to therapy? **AND**

   □ No □ Yes

2. Does the member have improvement in asthma symptoms or asthma exacerbations as evidenced by decrease in one or more of the following:
   a. Use of systemic corticosteroids
   b. Hospitalizations
   c. ER visits
   d. Unscheduled visits to healthcare provider
   e. Improvement from baseline in forced expiratory volume in 1 second (FEV_1)?

   □ No □ Yes

7 – Prescriber Sign-Off

Additional Information –

1. **Please submit chart notes/medical records for the patient that are applicable to this request.**
2. **If member has not tried preferred agent(s) please provide rationale/explanation and any additional supporting information that should be taken into consideration for the requested medication:**

_____
_____
_____

I certify that the information provided is accurate. Supporting documentation is available for State audits.

Prescriber Signature:	**Date:**