Print Reset

CardinalCare
Virginia's Medicaid Program

**COMMONWEALTH OF VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES**

**Service Authorization (SA) Form**

**Tezspire® (tezepelumab-ekko)**

If the following information is not complete, correct, or legible, the SA process can be delayed.

Please use one form per member.

## MEMBER INFORMATION

**Last Name:** _____

**First Name:** _____

**Medicaid ID Number:** _____

**Date of Birth:** _____

**Weight in Kilograms**: _____

## PRESCRIBER INFORMATION

**Last Name:** _____

**First Name:** _____

**NPI Number:** _____

**Phone Number:** _____

**Fax Number:** _____

## DRUG INFORMATION

**Drug Name/Form:** _____

**Strength:** _____

**Dosing Frequency:** _____

**Length of Therapy:** _____

**Quantity per Day:** _____

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 theses combinations have **NOT** been established and will **NOT** be permitted.

*(Form continued on next page.)*

**Member's Last Name:** **Member's First Name:**

## DIAGNOSIS AND MEDICAL INFORMATION

**For severe* asthma initial approval, complete the following questions to receive a 6-month approval:**

1. Is the member 12 years of age or older? **AND**

   ☐ Yes ☐ No

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

   ☐ Yes ☐ No

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

   ☐ Yes ☐ No

4. Will this 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 (e.g., 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 a hospitalization? **AND**

   ☐ 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 ($FEV_1$)? **AND**

   ☐ Yes ☐ No

*(Form continued on next page.)*

**Member's Last Name:** **Member's First Name:**

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

   ☐ Yes ☐ No ☐ N/A

   **If N/A was selected for question 7 please answer the following:**

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

      ☐ Yes ☐ No

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

      ☐ Yes ☐ No

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

      ☐ Yes ☐ No

**For severe* asthma renewal, complete the following questions to receive a 12-month approval:**

8. Has the member been assessed for toxicity? **AND**

   ☐ Yes ☐ No

9. Does the member have improvement in asthma symptoms or asthma exacerbations as evidenced by 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):** |
|---|
| ▪ 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 $FEV_1$) < 60% |
| ▪ Exacerbations requiring oral systemic corticosteroids are generally more frequent and intense relative to moderate asthma |

*(Form continued on next page.)*

**Member's Last Name:** **Member's First Name:**

**Prescriber Signature (Required)** **Date**

By signature, the physician confirms the above information is accurate and verifiable by member records.

**Please include ALL requested information; Incomplete forms will delay the SA process.**

Submission of documentation does NOT guarantee coverage by the Department of Medical Assistance Services.

The completed form may be: **FAXED TO 800-932-6651**, phoned to 800-932-6648, or mailed to:

Prime Therapeutics Management LLC

Attn: GV – 4201

P.O. Box 64811

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