OKLAHOMA Health Care Authority

State of Oklahoma SoonerCare

Tezspire® (Tezepelumab-ekko) Prior Authorization Form

Member Name:_____ Date of Birth:_____ Member ID#:_____

Drug Information

☐ ***Physician billing (HCPCS code:_____)*** ☐ ***Pharmacy billing (NDC:_____)***

Dose:_____ Regimen:_____ Fill Date:_____

Billing Provider Information

SoonerCare Provider ID:_____ Provider Name:_____

Provider Phone:_____ Provider Fax:_____

Prescriber Information

Prescriber NPI:_____ Prescriber Name:_____

Prescriber Phone:_____ Prescriber Fax:_____ Specialty:_____

Clinical Information

For Initial Authorization: ***Initial approvals will be for the duration of 6 months.***

1. Does member have a diagnosis of Severe Asthma? Yes☐ No☐
2. Will this medication be used as add-on maintenance treatment? Yes☐ No☐
   A. If yes, please indicate member's daily medications and dose prescribed for treatment of this diagnosis:
   Drug/Dose:_____Drug/Dose:_____
3. Has the member experienced ≥ two asthma exacerbations requiring oral or injectable corticosteroids, or that resulted in hospitalization in the last 12 months? Yes☐ No☐
   A. If yes, please indicate dates/details:
   _____
4. Has member failed a medium-to-high dose inhaled corticosteroid (ICS) used compliantly for at least the past 12 months? Yes☐ No☐
   A. If yes, please indicate medication/dates: _____
5. Has the member failed at least 1 other asthma controller medication used in addition to the medium-to-high dose ICS compliantly for at least the past 3 months? Yes☐ No☐
   A. If yes, please indicate medication/dates: _____
6. For Tezspire® vial or pre-filled syringe, will it be administered in a health care setting by a health care professional prepared to manage anaphylaxis? Yes☐ No☐ N/A☐
7. For Tezspire® pre-filled pen, will it be administered by a health care professional prepared to manage anaphylaxis or has the member or caregiver been trained by a health care professional on subcutaneous administration, monitoring for any allergic reactions, and storage of Tezspire®? Yes☐ No☐ N/A☐
8. Was Tezspire® prescribed by a specialist or has the member been evaluated by a specialist within the last 12 months (or an advanced care practitioner with a supervising physician who is specialist)? Yes☐ No☐
   A. If "Yes", please indicate name of specialist:_____ Specialty:_____

For Continued Authorization:

1. Is the member compliant with therapy? Yes☐ No☐
2. Is the member responding well to therapy? Yes☐ No☐

Prescriber Signature: _____ **Date:** _____
(By signature, the physician confirms the criteria information above is accurate and verifiable in patient records.)

Pharmacist Signature: _____ **Date:** _____

Failure to complete this form in full will result in processing delays. Please do not send in chart notes. Specific information will be requested if necessary.

PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:	CONFIDENTIALITY NOTICE
University of Oklahoma College of Pharmacy Pharmacy Management Consultants Product Based Prior Authorization Unit Fax: 1-800-224-4014 Phone: 1-800-522-0114 Option 4	*This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.*