Mountain-Pacific Quality Health
Partnering within our communities to provide solutions for better health

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Montana Healthcare Programs Prior Authorization Request Form for Use of Tezspire® (tezepelumab)

Member Name:	DOB:	Date:
Member ID:	Prescriber Phone:	
Prescriber Name/Specialty if applicable:	Prescriber Fax:	
Dosage Requested:		

Please complete below information for applicable situation, Initiation or Continuation of therapy:

☐ INITIATION OF THERAPY

Member must meet **all** of the following criteria:

1. Member is greater than or equal to 12 years of age: ☐ Yes ☐ No
2. Member has a diagnosis of **severe** asthma: ☐ Yes ☐ No
3. Medication must be prescribed by or in consult with an appropriate specialist:

   ☐ Allergy ☐ Pulmonology ☐ Immunology

   Action required: If not in a specialty clinic or written by a specialist, copy of annual specialty consult with an appropriate specialist is required (please attach copy of consult):

   Name of specialist: _____ **Contact date:** _____
4. Member has a history of severe asthma attacks despite treatment with the following medications at optimized doses in combination for three consecutive months:

   - Inhaled corticosteroid (ICS):

     Name: _____ Dates: _____
   - Long-acting beta2-agonist (LABA):

     Name: _____ Dates: _____
5. Member will continue to use ICS in combination with LABA inhaler, at optimized doses, concurrently with Tezspire®: ☐ Yes ☐ No
6. Provider attests member will **not** use Tezspire® concomitantly with other biologics: ☐ Yes ☐ No

   If no, please provide rationale why multiple biologics are necessary: _____

   _____

   _____

LIMITATIONS:

Maximum dosage allowed: 210mg SQ every 4 weeks

Initial authorization will be issued for 1 year.

☐ CONTINUATION OF THERAPY

1. Member has been adherent to Tezspire® and ICS/LABA therapy: ☐ Yes ☐ No (will be verified through claims history)
2. Documentation is attached supporting positive response to therapy as demonstrated by a reduction in the frequency and/or severity of symptoms and exacerbations or medication dose reduction: ☐ Yes ☐ No
3. Annual specialist consult attached if prescriber is not a specialist: ☐ Yes ☐ No
   ☐ N/A - prescriber is a specialist.

Reauthorization will be issued for 1 year.

Please complete form, including required attachments, and fax to Drug Prior Authorization Unit at 1-800-294-1350.

07/2022