BlueCross BlueShield Federal Employee Program

TEZSPIRE
PRIOR APPROVAL REQUEST

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		

PHYSICIAN COMPLETES

All approved requests are subject to review by a clinical specialist for final validation and coverage determination once all required documentation has been received. Current utilization, including samples, does not guarantee approval of coverage.

Tezspire

(tezepelumab-ekko)

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

NOTE: Form must be completed in its **entirety** for processing

Is this request for brand or generic? ❑Brand ❑Generic

1. Will the patient need more than 3 units every 84 days? ❑Yes* ❑No
   If YES, please specify the requested quantity: _____ units every 84 days
2. Has the patient been on this medication continuously for the last **6 months** excluding samples? ***Please select answer below:***

   ❑**NO** – this is **INITIATION** of therapy, please answer the following questions:
   - a. Does the patient have a diagnosis of severe asthma? ❑Yes ❑No
   - b. Has patient had inadequate control of asthma symptoms after a minimum of 3 months of compliant use defined as greater than or equal to 50 percent adherence with a corticosteroid inhaler in combination with a long acting beta2-agonist within the past 6 months? ❑Yes ❑No*
     If NO, has patient had inadequate control of asthma symptoms after a minimum of 3 months of compliant use defined as greater than or equal to 50 percent adherence with a corticosteroid inhaler in combination with a long acting muscarinic antagonist within the past 6 months? ❑Yes ❑No
   - c. Will this medication be used as add-on maintenance treatment? ❑Yes* ❑No
     If YES, please answer the following questions:
     - i. Will this medication be used in combination with a medium or high-dose inhaled corticosteroid? ❑Yes ❑No
     - ii. Will this medication be used in combination with an additional controller medication such as a long acting beta2 agonist or leukotriene modifier? ❑Yes ❑No

   ❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following questions:
   - a. Does the patient have a diagnosis of asthma? ❑Yes ❑No
   - b. Has the patient had a documented decrease in exacerbations **OR** an improvement in symptoms? ❑Yes ❑No
   - c. Has the patient decreased utilization of rescue medications? ❑Yes ❑No
   - d. Has the patient been compliant on Tezspire therapy? ❑Yes ❑No
   - e. Will this medication be used as add-on maintenance treatment? ❑Yes ❑No
3. Will the patient be given live vaccines while on this therapy? ❑Yes ❑No
4. Will this medication be used for the relief of acute bronchospasm or status asthmaticus? ❑Yes ❑No
5. Will this medication be used in combination with another monoclonal antibody for the treatment of asthma or COPD? ❑Yes ❑No
   If YES, please specify the medication: _____

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To ensure a quick and accurate response to your prior approval request, please **submit medical records (e.g., chart notes, laboratory values)** pertaining to the diagnosis only. Please do not send in medical records of other diagnoses in order to streamline the process. Please use this page as a **guideline** of what documentation is required to process the prior authorization request.

***For more efficient processing, please provide the page number of the documented information in the medical record**

Documentation Required:

❑**NOT** used for the relief of acute bronchospasm or status asthmaticus **PAGE _____ of _____**

❑**NO** dual therapy with another monoclonal antibody **PAGE _____ of _____**

❑**NOT** given concurrently with live vaccines **PAGE _____ of _____**

Documentation Required for INITIATION of Therapy:

❑Severe asthma **PAGE _____ of _____**

❑Inadequate control of symptoms after a minimum of 3 months of compliant use with greater than or equal to 50% adherence with **ONE** of the following within the past 6 months: **PAGE _____ of _____**

- Inhaled corticosteroids & long acting $beta_2$ agonist
- Inhaled corticosteroids & long acting muscarinic antagonist

❑Used as add-on maintenance treatment and will be receiving **ALL** of the following: **PAGE _____ of _____**

- Medium or high-dose inhaled corticosteroid
- Additional controller medication (e.g., long acting $beta_2$ agonist, leukotriene modifier)

Documentation Required for CONTINUATION of Therapy:

❑Decreased exacerbations **OR** improvement in symptoms **PAGE _____ of _____**

❑Decreased utilization of rescue medications **PAGE _____ of _____**

❑Compliant on therapy **PAGE _____ of _____**

❑Used as add-on maintenance treatment **PAGE _____ of _____**