Tezspire

Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-855-330-1720**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-888-877-0518.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

Patient's Name: ______________________________ **Date**: ________________________________
Patient's ID: ________________________________ **Patient's Date of Birth:** ________________
Physician's Name: ____
Specialty: __________________________________ **NPI#:** ________________________________
Physician Office Telephone: __________________ **Physician Office Fax:** ___________________

<u>Referring</u> Provider Info: ❑ **Same as Requesting Provider**
Name: ____ **NPI#:** ______________________________
Fax: _________________________ **Phone:** _____________________

<u>Rendering</u> Provider Info: ❑ **Same as Referring Provider** ❑ **Same as Requesting Provider**
Name: ____ **NPI#:** ______________________________
Fax: _________________________ **Phone:** _____________________

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

<u>Required Demographic Information:</u>

Patient Weight: __________________________*kg*

Patient Height: __________________________*cm*

Please indicate the place of service for the requested drug:

❑ *Ambulatory Surgical* ❑ *Home* ❑ *Off Campus Outpatient Hospital*
❑ *On Campus Outpatient Hospital* ❑ *Office* ❑ *Pharmacy*

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Tezspire SOC SGM 5104-A - 03.2023.

Site of Service Questions:

A. Where will this drug be administered?
- ❑ Ambulatory surgical, *skip to Clinical Questions*
- ❑ Home infusion, *skip to Clinical Questions*
- ❑ Off-campus Outpatient Hospital
- ❑ On-campus Outpatient Hospital
- ❑ Physician office, *skip to Clinical Questions*
- ❑ Pharmacy, *skip to Clinical Questions*

B. Is this request to continue previously established treatment with the requested medication?
- ❑ Yes - This is a continuation of an existing treatment.
- ❑ No - This is a new therapy request (patient has not received requested medication in the last 6 months). *skip to Clinical Criteria Questions*

C. Has the patient experienced an adverse event with the requested product that has not responded to conventional interventions (eg acetaminophen, steroids, diphenhydramine, fluids, other pre-medications or slowing of the infusion rate) or a severe adverse event (anaphylaxis, anaphylactoid reactions, myocardial infarction, thromboembolism, or seizures) during or immediately after an infusion? ***ACTION REQUIRED: If Yes, Attach supporting clinical documentation***. ❑ Yes, *skip to Clinical Criteria Questions* ❑ No

D. Is the patient medically unstable which may include respiratory, cardiovascular, or renal conditions that may limit the member's ability to tolerate a large volume or load or predispose the member to a severe adverse event that cannot be managed in an alternate setting without appropriate medical personnel and equipment? ***ACTION REQUIRED: If Yes, Attach supporting clinical documentation.*** ❑ Yes, *skip to Clinical Criteria Questions* ❑ No

E. Does the patient have significant behavioral issues and/or physical or cognitive impairment that would impact the safety of the infusion therapy AND the patient does not have access to a caregiver? ***ACTION REQUIRED: If Yes, Attach supporting clinical documentation.*** ❑ Yes ❑ No

Clinical Criteria Questions:

What is the ICD-10 code? ___________

1. What is the diagnosis?

❒ Severe asthma, *Continue to #2*

❒ Other, please specify: _________________________, *Continue to #2*

2. Is Tezspire prescribed by or in consultation with an allergist/immunologist or pulmonologist?

❒ Yes, *Continue to #3*

❒ No, *Continue to #3*

3. Is this request for continuation of therapy with Tezspire?

❒ Yes, *Continue to #4*

❒ No, *Continue to #10*

4. Is the patient currently receiving Tezspire through samples or a manufacturer's patient assistance program?

❒ Yes, *Continue to #10*

❒ No, *Continue to #5*

❒ Unknown, *Continue to #10*

5. Has asthma control improved on Tezspire treatment as demonstrated by a reduction in the frequency and/or severity of symptoms and exacerbations? ***ACTION REQUIRED***: If Yes, please attach supporting chart notes or medical record documentation of improved asthma control.

❒ Yes, *Continue to #7*

❒ No, *Continue to #6*

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6. Has asthma control improved on Tezspire treatment as demonstrated by a reduction in the daily maintenance oral corticosteroid dose? ***ACTION REQUIRED***: If Yes, please attach supporting chart notes or medical record documentation of improved asthma control.

❒ Yes, *Continue to #7*

❒ No, *Continue to #7*

7. Will the patient continue to use maintenance asthma treatments (e.g., inhaled corticosteroid, additional controller) in combination with Tezspire?

❒ Yes. *Continue to #8*

❒ No, *Continue to #8*

8. Will the patient receive Tezspire concomitantly with other biologics indicated for asthma (e.g., Cinqair, Dupixent, Fasenra, Nucala, Xolair)?

❒ Yes, *Continue to #9*

❒ No, *Continue to #9*

9. Is the patient 12 years of age or older?

❒ Yes, *No further questions*

❒ No, *No further questions*

10. Does the patient have uncontrolled asthma as demonstrated by experiencing two or more asthma exacerbations requiring oral or injectable corticosteroid treatment within the past year? ***ACTION REQUIRED***: If Yes, please submit supporting chart notes, medical records, or claims history of previous corticosteroid use for asthma exacerbations.

❒ Yes, *Continue to #13*

❒ No, *Continue to #11*

11. Does the patient have uncontrolled asthma as demonstrated by experiencing one or more asthma exacerbation resulting in hospitalization or emergency medical care visit within the past year? ***ACTION REQUIRED***: If Yes, please submit supporting chart notes, medical records of previous asthma exacerbations requiring hospitalization or emergency medical visit.

❒ Yes, *Continue to #13*

❒ No, *Continue to #12*

12. Does the patient have uncontrolled asthma as demonstrated by experiencing poor symptom control (frequent symptoms or reliever use, activity limited by asthma, night waking due to asthma) within the past year? ***ACTION REQUIRED***: If Yes, please submit supporting chart notes or medical records.

❒ Yes, *Continue to #13*

❒ No, *Continue to #13*

13. Prior to receiving Tezspire, did the patient have inadequate asthma control despite current treatment with both of the following medications at optimized doses: 1) High dose inhaled corticosteroids AND 2) Additional controller (i.e., long acting beta2-agonist, long acting muscarinic antagonist, leukotriene modifier, or sustained-release theophylline)? ***ACTION REQUIRED***: If Yes, please attach supporting chart notes, medical records, or claims history of previous medications tried including drug, dose, frequency, and duration.

❒ Yes, *Continue to #14*

❒ No, *Continue to #14*

14. Will the patient continue to use maintenance asthma treatments (e.g., inhaled corticosteroid, additional controller) in combination with Tezspire?

❒ Yes, *Continue to #15*

❒ No, *Continue to #15*

15. Will the patient receive Tezspire concomitantly with other biologics indicated for asthma (e.g., Cinqair, Dupixent, Fasenra, Nucala, Xolair)?

❒ Yes, *Continue to #16*

❒ No , *Continue to #16*

16. Is the patient 12 years of age or older?

❒ Yes, *No further questions*
❒ No, *No further questions*

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X____
Prescriber or Authorized Signature **Date (mm/dd/yy)**

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