Print Reset

United Healthcare Community Plan

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.

Fax this form to 1-866-940-7328

Pharmacy PA call center: 1-800-310-6826