Trillium Health Resources
Pharmacy Prior Approval Request for

Trillium HEALTH RESOURCES
Transforming Lives. Building Community Well-Being.

Monoclonal Antibodies: Tezspire

Member Information

1. Last Name: _____ 2. First Name: _____
3. Trillium ID #: _____ 4. Date of Birth: _____ 5. Gender: _____

Prescriber Information

1. Prescriber Name: _____ 2. NPI #: _____
3. Requestor Name (Nurse/Office Staff): _____
4. Mailing Address: _____ City: _____ State: ____ Zip: _____
5. Phone #: _____ Ext. _____ Fax #: _____

Drug Information

1. Drug Name: **Inbrija** 2. Strength: _____ 3. Quantity per 30 Days: _____
4. Length of Therapy: ☐ 30 Days ☐ 60 Days ☐ 90 Days ☐ 120 Days ☐ 180 Days ☐ 365 Days ☐ Other _____

Clinical Information

Initial Approval:

1. Is the member age 12 years of age or older? ☐ Yes ☐ No
2. Does the member have a diagnosis of severe Asthma with evidence of severe disease? ☐ Yes ☐ No
3. Does the member have at least 1 of the following? ☐ Yes ☐ No Please indicate which one(s). _____
   a. Symptoms throughout the day
   b. Nighttime awakenings, often 7x/week
   c. SABA use for symptom control occurring several times per day
   d. Extremely limited normal activities
   e. Lung function (percent predicted FEV1) < 60%
   f. Exacerbations requiring oral systemic corticosteroids generally more frequent and intense relative to moderate asthma
4. Is Tezspire being used for add-on maintenance treatment for a member who regularly received BOTH of the following?
   ☐ Yes ☐ No
   a. Medium- to high-dose inhaled corticosteroids
   b. An additional controller medication (e.g., long-acting beta agonist, leukotriene modifiers
5. Has the member had, in the previous year, ≥ 2 exacerbations requiring oral or injectable corticosteroid treatment (in addition to the regular maintenance therapy defined above) OR one exacerbation resulting in a hospitalization? ☐ Yes ☐ No
6. Is there a baseline measurement of ≥ 1 of the following for assessment of clinical status? ☐ Yes ☐ No Please indicate which one(s). _____
   a. Use of systemic corticosteroids
   b. Use of inhaled corticosteroids
   c. Number of hospitalizations, ER visits, or unscheduled visits to healthcare provider due to condition
   d. FEV1
7. Will the member use Tezspire for the relief of acute bronchospasm or status asthmaticus? ☐ Yes ☐ No
8. Will the member use Tezspire in combination with anti-IgE, anti-IL4, or anti-IL5 monoclonal antibody agents (e.g., benralizumab, omalizumab, mepolizumab, reslizumab, dupilumab)? ☐ Yes ☐ No
9. Does the member have hypersensitivity to tezepelumab-ekko (Tezspire) or any of its excipients? ☐ Yes ☐ No

10. Does the member have an active or untreated helminth infection? ☐ Yes ☐ No
11. Will Tezspire be administered concurrently with live vaccines? ☐ Yes ☐ No

Initial approval can be for up to 6 months

For continuation of therapy, please answer questions 1-13

12. While on Tezspire, has the member experienced improvement in asthma symptoms, asthma exacerbations, or airway function as evidenced by decrease in ≥ 1 of the following? ☐ Yes ☐ No Please indicate which one(s)._____
    a. Use of systemic corticosteroids
    b. Two-fold or greater decrease in inhaled corticosteroid use for at least 3 days
    c. Hospitalizations
    d. ER visits
    e. Unscheduled visits to healthcare provider
    f. Improvement from baseline in FEV1
13. Has the member experienced any serious treatment-related adverse events (e.g., parasitic [helminth] infection, severe hypersensitivity reactions)? ☐ Yes ☐ No

Reauthorizations can be for up to 6 months

** Please provide medical records documenting the member's current Asthma status and response to Tezspire treatment**

Signature of Prescriber: _____ Date: _____

(Prescriber Signature Mandatory)

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.