

TEZSPIRE

PRIOR AUTHORIZATION REQUEST

PRESCRIBER FAX FORM

Only the prescriber may complete this form. This form is for prospective, concurrent, and retrospective reviews.

The following documentation is **REQUIRED**. Incomplete forms will be returned for additional information. For formulary information please visit www.myprime.com. Start saving time today by filling out this form electronically. Visit covermymeds.com to begin using this free service.

What is the priority level of this request?

- Standard review
- Expedited/Urgent review – prescriber certifies that waiting for a standard review could seriously harm the patient's life, health or ability to regain maximum function

PATIENT AND INSURANCE INFORMATION

Today's Date: _____

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
Patient Address:	City, State, Zip:	Patient Telephone:	
Member ID Number:	Group Number:		

PRESCRIBER/CLINIC INFORMATION

Prescriber Name:	Prescriber NPI#:	Specialty:	Contact Name:
Clinic Name:	Clinic Address:		
City, State, Zip:	Phone #:	Secure Fax #:	

PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST

Patient's Diagnosis: <input type="checkbox"/> Asthma; severe <input type="checkbox"/> Chronic rhinosinusitis with nasal polyps (CRSwNP) <input type="checkbox"/> Other (ICD code plus description): _____	
Patient's Diagnosis (ICD code plus description):	
Medication Requested:	Strength:
Dosing Schedule:	Quantity per Month:
For all requests: 1. Is the patient currently treated with the requested agent? <input type="checkbox"/> Yes <input type="checkbox"/> No 2. Has the patient been treated with the requested agent (starting on samples is not approvable) within the past 90 days? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, is the patient at risk if therapy is changed? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain risk: _____ _____	
3. Does the patient have any FDA labeled contraindications to the requested agent? A contraindication is a medical situation where a treatment should be avoided because it could cause harm to a person..... <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please specify FDA labeled contraindication: _____ _____	
4. Is the patient's age within FDA labeling for the requested indication for the requested agent?..... <input type="checkbox"/> Yes <input type="checkbox"/> No If no, please provide support for using the requested agent for the patient's age for the requested indication: _____ _____ _____	
5. Is the prescriber a specialist in the area of the patient's diagnosis, or has the prescriber consulted with a specialist in the area of the patient's diagnosis? For example, an allergist, immunologist, or pulmonologist for a diagnosis of asthma, OR an otolaryngologist, allergist, immunologist, or pulmonologist for a diagnosis of CRSwNP? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Please continue to the next page.

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6. Will the patient be using the requested agent in combination with another immunomodulatory agent (e.g., TNF inhibitors, JAK inhibitors, IL-4 inhibitors) [Abrilada, Actemra, Adalimumab, Adbry, Amjevita, Arcalyst, Avsola, Avtozma, Benlysta, Bimzelx, Cibinqo, Cimzia, Cinqair, Cosentyx, Cyltezo, Dupixent, Ebglyss, Enbrel, Entyvio, Fasenra, Hadlima, Hulio, Humira, Hyrimoz, Idacio, Ilaris, Ilumya, Imuldosa, Inflectra, Infiximab, Kevzara, Kineret, Leqselvi, Litfulo, Nemluvio, Nucala, Olumiant, Omlyclo, Omvoh, Opzelura, Orenzia, Otezla, Otezla XR, Otulfi, Pyzchiva, Remicade, Renflexis, Rhapsido, Riabni, Rinvoq, Rituxan, Rituxan Hycela, Ruxience, Saphnelo, Selarsdi, Siliq, Simlandi, Simponi, Simponi ARIA, Skyrizi, Sotyktu, Spevigo subcutaneous injection, Starjemza, Stelara, Steqeyma, Taltz, Tezspire, Tofidence, Tremfya, Truxima, Tyenne, Tyruko, Tysabri, Ustekinumab, Velsipity, Wezlana, Xeljanz, Xeljanz XR, Xolair, Yesintek, Yuflyma, Yusimry, Zeposia, Zymfentra]? Yes No
- If yes, does the prescribing information for the requested agent limit the use with another immunomodulatory agent? Yes No
- If no, is there support for the use of combination therapy? Please note, a submitted copy of clinical trials, phase III studies, or guidelines is required. Yes No
- If yes, please submit supporting copy of clinical trials, phase III studies, and/or guidelines.**
7. Please list all reasons for selecting the requested medication, strength, dosing schedule, and quantity over alternatives (e.g., contraindications, allergies, history of adverse drug reactions to alternatives, lower dose has been tried, information supporting dose over FDA max). **Please note, documentation may be required:** _____
- _____
- _____

For Asthma; severe requests:

8. Does the patient have a history of uncontrolled asthma while on asthma control therapy (e.g., inhaled corticosteroid [ICS]/long-acting beta-2 agonist [LABA] combination therapy) as demonstrated by ONE of the following? Yes No
- If yes, please select ALL that apply:
- Frequent severe asthma exacerbations requiring two or more courses of systemic corticosteroids (steroid burst) within the past 12 months
 - Serious asthma exacerbations requiring hospitalization, mechanical ventilation, or visit to the emergency room or urgent care within the past 12 months
 - Controlled asthma that worsens when the doses of inhaled and/or systemic corticosteroids are tapered
 - Baseline (prior to therapy with the requested agent) Forced Expiratory Volume (FEV1) that is less than 80% of predicted
9. Does the patient's medication history (excluding sample use) indicate use of a biologic immunomodulator agent that is FDA labeled or supported in compendia (AHFS, DrugDex 1 or 2a level of evidence, or NCCN 1 or 2a recommended use) for the treatment of asthma within the past 12 months? Yes No
- If yes, please specify biologic agent tried: _____
10. Including the requested agent, is the patient currently treated with a biologic immunomodulator agent that is FDA labeled or supported in compendia (AHFS, DrugDex 1 or 2a level of evidence, or NCCN 1 or 2a recommended use) for the treatment of asthma? Yes No
- If yes, is the patient currently treated with an inhaled corticosteroid for at least 3 months that is adequately dosed to control symptoms AND has been adherent for 90 days within the past 120 days? Please note, chart notes are required for review. Yes No
- If yes, please submit chart notes.
11. Is the patient currently treated with a maximally tolerated inhaled corticosteroid for at least 3 months AND has been adherent for 90 days within the past 120 days? Please note, chart notes are required for review. Yes No
- If yes, please submit chart notes.
12. Does the patient have an intolerance or hypersensitivity to ONE inhaled corticosteroid? Yes No
- If yes, please explain intolerance/hypersensitivity: _____
- _____
- If no, does the patient have an FDA labeled contraindication to ALL inhaled corticosteroids? Yes No
- If yes, please specify FDA labeled contraindication: _____
- _____

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13. Is the patient currently treated for at least 3 months AND has been adherent for 90 days within the past 120 days with ONE of the following: 1) a long-acting beta-2 agonist (LABA), 2) a long-acting muscarinic antagonist (LAMA), 3) a leukotriene receptor antagonist (LTRA), OR 4) theophylline? Please note, chart notes are required for review. Yes No

If yes, please submit chart notes.

If no, does the patient have an intolerance or hypersensitivity to ONE long-acting beta-2 agonist (LABA), long-acting muscarinic antagonist (LAMA), leukotriene receptor antagonist (LTRA), or theophylline? Yes No

If yes, please explain intolerance/hypersensitivity: _____

If no, does the patient have an FDA labeled contraindication to ALL long-acting beta-2 agonists (LABA) AND long-acting muscarinic antagonists (LAMA)? Yes No

If yes, please specify FDA labeled contraindication: _____

14. Will the patient continue asthma control therapy (e.g., ICS, ICS/LABA, LTRA, LAMA, theophylline) in combination with the requested agent? Yes No

For Chronic rhinosinusitis with nasal polyps (CRSwNP) requests:

15. Does the patient have at least TWO of the following symptoms consistent with chronic rhinosinusitis (CRS): 1) nasal discharge (rhinorrhea or post-nasal drainage), 2) nasal obstruction or congestion, 3) loss or decreased sense of smell (hyposmia), AND/OR 4) facial pressure or pain?? Yes No

16. Has the patient had symptoms consistent with chronic rhinosinusitis (CRS) for at least 12 consecutive weeks?..... Yes No

17. Has the patient's diagnosis been confirmed by ONE of the following: 1) anterior rhinoscopy, 2) nasal endoscopy, OR 3) computed tomography (CT) of the sinuses? Yes No

18. Has the patient tried and had an inadequate response to ONE intranasal corticosteroid (e.g., fluticasone nasal spray, mometasone nasal spray, Sinuva) after at least a 4-week duration of therapy? Yes No

If no, does the patient have an intolerance or hypersensitivity to ONE intranasal corticosteroid (e.g., fluticasone nasal spray, mometasone nasal spray, Sinuva)? Yes No

If yes, please explain intolerance/hypersensitivity: _____

If no, does the patient have an FDA labeled contraindication to ALL intranasal corticosteroids? Yes No

If yes, please specify FDA labeled contraindication: _____

19. Is the patient currently treated with standard nasal polyp maintenance therapy (e.g., nasal saline irrigation, intranasal corticosteroids [e.g., fluticasone nasal spray, mometasone nasal spray, Sinuva])? Yes No

If yes, please specify agent: _____

20. Will the patient continue standard nasal polyp maintenance therapy (e.g., nasal saline irrigation, intranasal corticosteroids [e.g., fluticasone nasal spray, mometasone nasal spray, Sinuva]) in combination with the requested agent? Yes No

For renewal requests:

21. Has the patient had clinical benefit with the requested agent? Yes No

For Asthma; severe requests:

22. Is the patient currently treated within the past 90 days AND compliant with asthma control therapy (e.g., inhaled corticosteroids [ICS], ICS/long-acting beta-2 agonist [ICS/LABA], leukotriene receptor antagonist [LTRA], long-acting muscarinic antagonist [LAMA], theophylline)? Please note, chart notes are required for review..... Yes No

If yes, please submit chart notes.

For Chronic rhinosinusitis with nasal polyps (CRSwNP) requests:

23. Will the patient continue standard nasal polyp maintenance therapy (e.g., nasal saline irrigation, intranasal corticosteroids [e.g., fluticasone nasal spray, mometasone nasal spray, Sinuva]) in combination with the requested agent? Yes No

Please continue to the next page.

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
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