US Family Health Plan
Prior Authorization Request Form for
tezepelumab-ekko (Tezspire)

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be faxed to 855-273-5735

OR

The patient may attach the completed form to the prescription and **mail** it to:
Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? **Call 1-877-880-7007**

Prior authorization expires after 12 months. Renewal PA criteria will be approved indefinitely. For renewal of therapy an initial USFHP prior authorization approval is required.

Step 1 **Please complete patient and physician information** (please print):

Patient Name:		Physician Name:	
Address:		Address:	
Sponsor ID #		Phone #:	
Date of Birth:		Secure Fax #:	

Step 2 **Please complete the clinical assessment:**

1. Has the patient received this medication under the USFHP benefit in the last 6 months? *Please choose "No" if the patient did not previously have a USFHP approved PA for Tezspire.*	☐ Yes Proceed to question **2**	☐ No Skip to question **3**
2. Has the patient had a positive response to therapy with a decrease in asthma exacerbations, improvements in forced expiratory volume in one second (FEV1) or decrease in oral corticosteroid use?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
3. Is the patient greater than or equal to 12 year(s) of age?	☐ Yes Proceed to question **4**	☐ No **STOP** **Coverage not approved**
4. Is the requested medication prescribed by an allergist, immunologist, or pulmonologist?	☐ Yes Proceed to question **5**	☐ No **STOP** **Coverage not approved**
5. Does the patient have a diagnosis of severe persistent asthma?	☐ Yes Proceed to question **6**	☐ No **STOP** **Coverage not approved**
6. Does the provider acknowledge the FDA warnings and precautions associated with Tezspire?	☐ Yes Proceed to question **7**	☐ No **STOP** **Coverage not approved**
7. Is the patient's asthma uncontrolled, despite adherence to optimized medication therapy regimen, defined as requiring hospitalization for asthma in past year?	☐ Yes Proceed to question **10**	☐ No Proceed to question **8**

8.	**Is the patient's asthma uncontrolled, despite adherence to optimized medication therapy regimen, defined as requiring two courses of corticosteroids for asthma exacerbation in past year?**	☐ Yes Proceed to question **10**	☐ No Proceed to question **9**
9.	**Is the patient's asthma uncontrolled, despite adherence to optimized medication therapy regimen, defined as requiring daily high-dose inhaled corticosteroids with inability to taper off the inhaled corticosteroids?**	☐ Yes Proceed to question **10**	☐ No **STOP** **Coverage not approved**
10.	**Has the patient tried and failed an adequate course (3 months) of TWO of the following while using a high-dose inhaled corticosteroid: long-acting beta agonist (LABA, for example, Serevent, Striverdi), OR long acting muscarinic antagonist (LAMA, for example, Spiriva, Incruse), OR leukotriene receptor antagonist (for example, Singulair, Accolate, Zyflo)?**	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**

Step 3

I certify the above is true to the best of my knowledge. Please sign and date:

Prescriber Signature _____ Date _____