Member Name: _____ Member ID: _____ Member DOB: _____

Drug Name: _____ Strength: _____ Directions: _____

Physician Name: _____ Physician Phone #: _____ Specialty: _____

Physician Fax #: _____ Pharmacy Name: _____Pharmacy Phone: _____

Horizon NJ Health
Tezepelumab-ekko (Tezspire) – Medical Necessity Request
****Complete pages 1-2 for New/Initial requests****

Diagnosis:

□ **Asthma**

1. What is the prescriber's specialty managing the medication?
   □ Allergy □ Pulmonology □ Other: _____
2. Will the medication be administered by a healthcare provider? **Yes or No**
3. Please indicate the severity of the asthma: □ mild □ moderate □ severe
4. Does the member have asthma with an eosinophilic phenotype? **Yes or No**
   - **If Yes**, can member try a Fasenra instead? **Yes** or **No**
     - **If Yes**, please complete the Mepolizumab (Nucala) and Benralizumab (Fasenra) form instead
     - **If No**, please provide reason why:
       _____
5. Does the member have allergic asthma? **Yes or No**
   - **If Yes**, can member try a Xolair instead? **Yes** or **No**
     - **If Yes**, please complete the Omalizumab (Xolair) form instead
     - **If No**, please provide reason why:
       _____
6. Has the member experienced ≥2 exacerbations requiring oral corticosteroids within the past 12 months? **Yes or No**
7. Has the member had serious asthma exacerbations requiring hospitalization, mechanical ventilation, or visit to the emergency room or urgent care within past 12 months? **Yes or No**
8. Does the member have a baseline Forced Expiratory Volume (FEV1) that is less than 80% of the predicted after bronchodilator use? **Yes or No**
9. Does the member's controlled asthma get worse when the dose of inhaled or systemic corticosteroids are tapered? **Yes or No**
10. Is the member currently being treated with a medium-high dose inhaled corticosteroid (ICS)? **Yes** or **No**
    - **If Yes**, please provide drug name, strength, directions AND dates filled within the past several months:
      _____
      _____
    - **If No**, can member try a medium-high dose inhaled corticosteroid instead? **Yes** or **No**
      - **If Yes**, please notify the pharmacy of the change
      - **If No**, please provide reason why: _____
        - Can the member try a low-dose inhaled corticosteroid instead? **Yes or No**
          - **If Yes,** please notify the pharmacy of the change
          - **If No,** please provide reason why member cannot use any inhaled corticosteroids**:**
            _____

Physician office's signature*_____ Print Name_____
***Form must be completed by prescribing physician or his/her representative**

Member Name: _____ Member ID: _____ Member DOB: _____

Drug Name: _____ Strength: _____ Directions: _____

Physician Name: _____ Physician Phone #: _____ Specialty: _____

Physician Fax #: _____ Pharmacy Name: _____Pharmacy Phone: _____

11. Is the member currently being treated with a long-acting beta agonist (LABA)? **Yes** or **No**
    - **If Yes**, please provide drug name AND dates filled within the past several months:
      _____
      _____
    - **If No**, can member try a LABA instead? **Yes** or **No**
      - **If Yes**, please notify the pharmacy of the change
      - **If No**, please provide reason why: _____

12. Is the member currently being treated with a leukotriene receptor antagonist (LTRA)? **Yes** or **No**
    - **If Yes**, please provide drug name AND dates filled within the past several months:
      _____
      _____
    - **If No**, can member try a LTRA instead? **Yes** or **No**
      - **If Yes**, please notify the pharmacy of the change
      - **If No**, please provide reason why: _____

13. Is the member currently being treated with a long-acting muscarinic antagonist (LAMA)? **Yes** or **No**
    - **If Yes**, please provide drug name AND dates filled within the past several months:
      _____
      _____
    - **If No**, can member try a LAMA instead? **Yes** or **No**
      - **If Yes**, please notify the pharmacy of the change
      - **If No**, please provide reason why: _____

14. Is the member currently being treated with any other controller medications? **Yes** or **No**
    - **If Yes**, please provide drug name(s) AND dates filled within the past several months:
      _____
      _____

15. What other asthma control therapy [e.g., ICS, LABA, LTRA, LAMA, etc.] will the member be taking together with the requested drug?
    _____

16. Will the member be using any other biologic drug [e.g., Dupilumab (Dupixent), omalizumab (Xolair), Reslizumab (Cinqair), Mepolizumab (Nucala), or Benralizumab (Fasenra)] with the requested drug? **Yes or No**
    - **If Yes,** please provide the drug name and diagnosis it is being used to treat:
      _____

□ **Other diagnosis**: _____

Physician office's signature*_____ Print Name_____
***Form must be completed by prescribing physician or his/her representative**

Member Name: _____ Member ID: _____ Member DOB: _____

Drug Name: _____ Strength: _____ Directions: _____

Physician Name: _____ Physician Phone #: _____ Specialty: _____

Physician Fax #: _____ Pharmacy Name: _____Pharmacy Phone: _____

Horizon NJ Health
Tezepelumab-ekko (Tezspire) – Medical Necessity Request
****Complete page 3 only for Subsequent/Renewal requests****

Diagnosis:

□ **Asthma**

1. Will the medication be administered by a healthcare provider? **Yes or No**

2. Has the member responded to therapy compared to baseline? **Yes or No**
   a. **If Yes**, how has the member responded to therapy compared to baseline? (check all that apply):
      □ Reduction in number of hospitalizations, need for mechanical ventilation, emergency room visits, or unscheduled visits to healthcare provider due to asthma exacerbations
      □ Reduction in the dose of inhaled/oral corticosteroids required to control the member's asthma
      □ Reduction in use of rescue medication
      □ Increase in pulmonary function tests (e.g., Forced Expiratory Volume) from baseline
      □ Decrease in symptoms and asthma exacerbations
      □ None of the above
      - **If None of the above**, please provide any additional clinical information pertaining to the request.

      _____

      _____

   b. **If No**, please provide reason to continue prescribing the requested drug:
      _____

3. Is the member currently being treated and has been compliant with standard asthma control therapy [e.g., inhaled corticosteroids (ICS), long-acting beta-2 agonist (LABA), leukotriene receptor antagonist (LTRA), long-acting muscarinic antagonist (LAMA)] for the past 90 days? **Yes or No**
   - **If No**, please provide reason why:
     _____

4. What other asthma control therapy [e.g., ICS, LABA, LTRA, LAMA, etc.] will the member be taking together with the requested drug?
   _____

5. Will the member be using any other biologic drug [e.g., Dupilumab (Dupixent), omalizumab (Xolair), Reslizumab (Cinqair), Mepolizumab (Nucala), or Benralizumab (Fasenra)] with the requested drug? **Yes or No**
   - **If Yes,** please provide drug name and diagnosis it is being used to treat:
     _____

□ **Other diagnosis**: _____

Physician office's signature*_____ Print Name_____
***Form must be completed by prescribing physician or his/her representative**