

Request for Prior Authorization
TEZEPELUMAB-EKKO (TEZSPIRE) PREFILLED
PEN
(PLEASE PRINT – ACCURACY IS IMPORTANT)

Does patient have one of the following?

Two (2) or more asthma exacerbations requiring oral or injectable corticosteroid treatment in the previous 12 months?

☐ Yes ☐ No

One or more asthma exacerbations resulting in hospitalization in the previous 12 months? ☐ Yes ☐ No

Will this medication be used as an add-on maintenance treatment? ☐ Yes ☐ No

Will medication be administered in patient's home? ☐ Yes ☐ No

Will medication be prescribed in combination with other biologics? ☐ Yes ☐ No

Renewals:

Document positive response to therapy: _____

Medical or contraindication reason to override trial requirements: _____

Attach lab results and other documentation as necessary.

Prescriber signature (Must match prescriber listed above.)	Date of submission
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IMPORTANT NOTE: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Health and Human Services, that the member continues to be eligible for Medicaid.