Cigna®

Fax completed form to: (855) 840-1678
If this is an URGENT request, please call (800) 882-4462
(800.88.CIGNA)

Tezspire
(tezepelumab)

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician Name:			*Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed.*		
Specialty:	* DEA, NPI or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* Cigna ID:	* Date of Birth:	
Office Fax:			* Patient Street Address:		
Office Street Address:			City:	State:	Zip:
City:	State:	Zip:	Patient Phone:		

Urgency:
☐ Standard ☐ Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)

Medication requested:
☐ Tezspire 210 mg/1.91 mL (110 mg/mL) syringe
☐ other (please specify):

ICD10:

Dose Quantity: Frequency of therapy:
Duration of therapy:

Is this initial therapy, is the patient restarting therapy, or is the patient currently receiving the requested medication?
☐ Initial therapy
☐ Currently receiving the requested medication
☐ Restarting therapy

Where will this medication be obtained?

☐ Accredo Specialty Pharmacy**
☐ Hospital Outpatient
☐ Retail pharmacy
☐ Other (please specify):

☐ Home Health / Home Infusion vendor
☐ Physician's office stock (billing on a medical claim form)
***Cigna's nationally preferred specialty pharmacy*

***Medication orders can be placed with Accredo via E-prescribe - Accredo (1620 Century Center Pkwy, Memphis, TN 38134-8822 | NCPDP 4436920), Fax 888.302.1028, or Verbal 866.759.1557*

Facility and/or doctor dispensing and administering medication:

Facility Name: State: Tax ID#:

Address (City, State, Zip Code):

Where will this drug be administered?
☐ Patient's Home
☐ Physician's Office
☐ Hospital Outpatient
☐ Other (please specify):

NOTE: Per some Cigna plans, infusion of medication MUST occur in the least intensive medically appropriate setting.

Is this patient a candidate for re-direction to an alternate setting (such as alternate infusion site, physician's office, home) with assistance of a Specialty Care Options Case Manager? ☐ Yes ☐ No (provide medical necessity rationale):

What is the indication or diagnosis?

☐ Asthma
☐ Atopic Dermatitis
☐ Chronic Obstructive Pulmonary Disease (COPD)
☐ Chronic Rhinosinusitis with Nasal polyps
☐ Chronic Spontaneous Urticaria
☐ All other indications or diagnoses:

Clinical Information:

Will the requested medication be used in combination with another monoclonal antibody therapy? Please note: Monoclonal antibody therapies are Adbry, Cinqair, Dupixent, Ebglyss, Fasenra, Nemluvio, Nucala, or Xolair. ☐ Yes ☐ No

(if asthma) Is the patient currently receiving the requested medication? ☐ Yes ☐ No

(if yes) Has the patient already received at least 6 months of therapy with the requested medication? Please Note: Answer No if the patient has received less than 6 months of therapy or if the patient is restarting therapy with the requested medication. ☐ Yes ☐ No

(if not currently receiving OR received less than 6 months) Is the requested medication being prescribed by (or in consultation with) an allergist, immunologist, or a pulmonologist? ☐ Yes ☐ No

(if not currently receiving OR received less than 6 months) Has the patient received at least 3 consecutive months of combination therapy with BOTH of the following: medium- or high-dose inhaled corticosteroid AND at least one additional asthma controller or asthma maintenance medication. Please Note: Examples of additional asthma controller or asthma maintenance medications are inhaled long-acting beta2-agonists, inhaled long-acting muscarinic antagonists, leukotriene receptor antagonists, and monoclonal antibody therapies for asthma (for example, Tezspire, Cinqair [reslizumab intravenous infusion], Fasenra [benralizumab subcutaneous injection], Nucala [mepolizumab subcutaneous injection]), Dupixent (dupilumab subcutaneous injection), Xolair (omalizumab subcutaneous injection). Please Note: Use of a combination inhaler containing both an inhaled corticosteroid and additional asthma controller/maintenance medication(s) would fulfill the requirement. ☐ Yes ☐ No

(if not currently receiving OR received less than 6 months) Does the patient have asthma that is uncontrolled or was uncontrolled at baseline as defined by ONE of the following: the patient experienced two or more asthma exacerbations requiring treatment with systemic corticosteroids in the previous year; OR the patient experienced one or more asthma exacerbations requiring a hospitalization, an emergency department visit, or an urgent care visit in the previous year; OR the patient has asthma that worsens upon tapering of oral (systemic) corticosteroid therapy? Please Note: "Baseline" is defined as prior to receiving Tezspire or another monoclonal antibody therapy for asthma. Examples of monoclonal antibody therapies for asthma include Cinqair, Dupixent, Fasenra, Nucala, Tezspire, and Xolair. ☐ Yes ☐ No

(if not currently receiving OR received less than 6 months) Has the patient had a forced expiratory volume in 1 second (FEV1) of less than 80% predicted? Please Note: The reduced FEV1 should not be due to smoking-related chronic obstructive pulmonary disease. ☐ Yes ☐ No

(if yes) Has the patient had an FEV1/forced vital capacity (FVC) of less than 0.80? ☐ Yes ☐ No

(if FEV1 not less than 80% predicted OR if FEV1/FVC not less than 0.80) Has the patient had an increase of greater than or equal to 12% AND greater than or equal to 200 mL in FEV1 following the administration of a standard dose of a short-acting bronchodilator? Note: The above lung function criteria may be met at anytime prior to or during asthma treatment. ☐ Yes ☐ No

(if no) Has the patient had an increase of greater than or equal to 12% AND greater than or equal to 200 mL in FEV1 between prescriber visits? Note: The above lung function criteria may be met at anytime prior to or during asthma treatment. ☐ Yes ☐ No

(if no) Has the patient had an increase of greater than or equal to 12% AND greater than or equal to 200 mL in FEV1 from baseline to after at least 4 weeks of asthma treatment? Note: The above lung function criteria may be met at anytime prior to or during asthma treatment. ☐ Yes ☐ No

(if no) Has the patient had a positive exercise challenge test? Note: The above lung function criteria may be met at anytime prior to or during asthma treatment. ☐ Yes ☐ No

(if no) Has the patient had a positive bronchial challenge test? Note: The above lung function criteria may be met at anytime prior to or during asthma treatment. ☐ Yes ☐ No

(if currently receiving) Will the patient continue to receive one inhaled corticosteroid or one inhaled corticosteroid-containing combination inhaler? ☐ Yes ☐ No

(if currently receiving) Has the patient responded to therapy with the requested medication, as determined by the prescriber? Please Note: Examples of a response to Tezspire therapy are decreased asthma exacerbations; decreased asthma symptoms;

decreased hospitalizations, emergency department/urgent care, or medical clinic visits due to asthma; improved lung function parameters; and/or a decreased requirement for oral corticosteroid therapy. ☐ Yes ☐ No

(if chronic rhinosinusitis w/nasal polyps) Is the patient currently receiving Tezspire? ☐ Yes ☐ No

(if yes) Has the patient already received at least 6 months of therapy with Tezspire? Please Note: Answer No if the patient has received less than 6 months of therapy or if the patient is restarting therapy with Tezspire. ☐ Yes ☐ No

(if currently receiving) Will the patient continue to receive therapy with an intranasal corticosteroid? ☐ Yes ☐ No

(if currently receiving) Has the patient responded to Tezspire therapy as determined by the prescriber? Please Note: Examples of a response to Tezspire therapy are reduced nasal polyp size, improved nasal congestion, reduced sinus opacification, decreased sino-nasal symptoms, and/or improved sense of smell. ☐ Yes ☐ No

(if not currently receiving OR received less than 6 months) Does the patient have chronic rhinosinusitis with nasal polyps as evidenced by direct examination, endoscopy, or sinus computed tomography (CT) scan? ☐ Yes ☐ No

(if not currently receiving OR received less than 6 months) Has the patient had the diagnosis of chronic rhinosinusitis with nasal polyps for at least 6 months? ☐ Yes ☐ No

(if not currently receiving OR received less than 6 months) Has the patient experienced two or more of the following symptoms for at least 8 weeks: nasal congestion, nasal obstruction, nasal discharge, and/or reduction/loss of smell? ☐ Yes ☐ No

(if not currently receiving OR received less than 6 months) Has the patient received at least 4 weeks of therapy with an intranasal corticosteroid? ☐ Yes ☐ No

(if not currently receiving OR received less than 6 months) Will the patient continue to receive therapy with an intranasal corticosteroid concomitantly with Tezspire? ☐ Yes ☐ No

(if not currently receiving OR received less than 6 months) Has the patient received at least one course of treatment with a systemic corticosteroid within the previous year? Please Note: One course of a systemic corticosteroid is greater than or equal to 3 consecutive days of treatment or one long-acting injectable dose. ☐ Yes ☐ No

(if no) Does the patient have a contraindication to systemic corticosteroid therapy? ☐ Yes ☐ No

(if no) Has the patient had prior surgery for nasal polyps? ☐ Yes ☐ No

(if not currently receiving OR received less than 6 months) Is the medication being prescribed by or in consultation with an allergist, immunologist, or an otolaryngologist (ear, nose and throat [ENT] physician specialist)? ☐ Yes ☐ No

Additional Pertinent Information:

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature:_____ **Date:**_____

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