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
☐ Tezspire 210 mg/1.91 mL Pen
☐ 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 for less than 6 months
☐ Currently receiving the requested medication and has been established on it for 6 or more months
☐ Restarting therapy

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

(if currently receiving) Has the patient responded to therapy as determined by the prescriber (Examples of a response to 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

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 your patient's diagnosis?

☐ Asthma
☐ Atopic Dermatitis
☐ Chronic Obstructive Pulmonary Disease (COPD)
☐ Chronic Rhinosinusitis with Nasal Polyposis (CRSwNP)
☐ Chronic Spontaneous Urticaria
☐ other (please specify):

Clinical Information:

Is the requested medication being prescribed by (or in consultation with) an allergist, immunologist, or a pulmonologist? ☐ Yes ☐ No

(if asthma) Did/Does the patient have a forced expiratory volume in 1 second (FEV1) of less than 80% predicted? Note: The reduced FEV1 should not be due to smoking-related chronic obstructive pulmonary disease ☐ Yes ☐ No

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

(if asthma) Did/Does the patient have an increase of greater than 12% AND greater than 200 mL in FEV1 following the administration of a standard dose of a short-acting bronchodilator? ☐ Yes ☐ No

(if no) Did/Does your patient have an increase of greater than 12% AND greater than 200 mL in FEV1 between prescriber visits? ☐ Yes ☐ No

(if no) Did/Does the patient have an increase of greater than 12% AND greater than 200 mL in FEV1 from baseline to after at least 4 weeks of asthma treatment? ☐ Yes ☐ No

(if no) Did/Does the patient have a positive exercise challenge test? ☐ Yes ☐ No

(if no) Did/Does the patient have a positive bronchial challenge test? ☐ Yes ☐ No

(if asthma) Has the patient received at least 3 consecutive months of therapy with a medium- or high-dosed inhaled corticosteroid? ☐ Yes ☐ No

(if yes) During the time the patient received the medium- or high-dosed inhaled corticosteroid, did the patient also receive at least 3 consecutive months of therapy with at least one additional asthma controller or asthma maintenance medication? Examples of additional asthma controller or asthma maintenance medications are inhaled long-acting beta2-agonists, inhaled long-acting muscarinic 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]). Use of a combination inhaler containing both a medium- or high-dose inhaled corticosteroid and additional asthma controller/maintenance medication(s) would fulfill the requirement for both. ☐ Yes ☐ No

(if asthma) At baseline, did the patient experience two or more asthma exacerbations requiring treatment with systemic corticosteroids in the previous year? Note: Baseline is defined as prior to receiving the requested medication or another monoclonal antibody therapy for asthma (examples include Cinqair, Dupixent, Fasenra, Nucala, Tezspire, and Xolair. ☐ Yes ☐ No

(if no) At baseline, did the patient experience one or more asthma exacerbation(s) requiring hospitalization, an emergency department visit, or an urgent care visit in the previous year? ☐ Yes ☐ No

(if no) At baseline, did/does the patient have asthma that worsens upon tapering of oral (systemic) corticosteroid therapy? ☐ Yes ☐ No

(if asthma) Will the patient use the requested medication with other Monoclonal Antibodies? ☐ Yes ☐ No

(if yes) Please provide the clinical rationale for concurrent use of these drugs.

Additional Pertinent Information: *Please provide any additional pertinent clinical information, including: if the patient is currently on the requested drug (with dates of use) and how they have been receiving it (for example: samples, out of pocket).*

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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Our standard response time for prescription drug coverage requests is 5 business days. If your request is urgent, it is important that you call us to expedite the request. View our Prescription Drug List and Coverage Policies online at cigna.com.

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