South Dakota Department of Social Services

Please note: All information below is required to process this request.
Fax to 1-844-403-1029
Mon-Sat: 7am to 7pm Central

Tezspire® Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)

Member Name:		
Insurance ID#:		
Date of Birth:		
Street Address:		
City:	State:	Zip:
Phone:		

Provider Information (required)

Provider Name:		
NPI#:	Specialty:	
Office Phone:		
Office Fax:		
Office Street Address:		
City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength: Dosage Form:
❑ Check if requesting **brand**	Directions for Use:
❑ Check if request is for **continuation of therapy**	

Clinical Information (required)

Select the diagnosis below:

❑ Severe asthma

❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical information:

Select if the requested medication is prescribed by or in consultation with one of the following specialists:

❑ Allergist/Immunologist ❑ Pulmonologist ❑ Other _____

For severe asthma, also answer the following:

Has the patient had two or more asthma exacerbations requiring systemic corticosteroids withn the past 12 months?

□ **Yes** □ **No** If yes, list corticosteroids tried_____

Has the patient had asthma-related hospitalization within the past 12 momths? □ **Yes** □ **No**

Has the patient tried high-dose inhaled corticosteroid (ICS) (i.e., greater than 500 mcg fluticasone propionate equivalent/day)? □ **Yes** □ **No** If yes, list ICS tried _____

Has the patient tried additional asthma controller medication (e.g., leukotriene receptor antagonist [e.g., montelukast], long-acting beta-2 agonist [LABA] [e.g., salmeterol], tiotropium) □ **Yes** □ **No** If yes, list drug tried _____

Has the patient tried one maximally-dosed combination ICS/LABA product (e.g., Advair [fluticasone propionate/ salmeterol], Symbicort [budesonide/formoterol], Breo Ellipta [fluticasone/vilanterol]) □ **Yes** □ **No** If so, list drug tried _____

Quantity limit requests:

What is the quantity requested per TREATMENT? _____ syringe every _____ weeks

What is the reason for exceeding the plan limitations?

❑ Titration or loading dose purposes

❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)

❑ Requested strength/dose is not commercially available

❑ Other: _____

Reauthorization: If this is a reauthorization request, answer the questions in the previous sections and the following below:

Does the patient demonstrates positive clinical response to therapy as evidenced by one of the following:

- A reduction in asthma exacerbations □ **Yes** □ **No**
- Improvement in forced expiratory volume in 1 second (FEV1) from baseline □ **Yes** □ **No**

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review? _____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-855-401-4262.
This form may be used for non-urgent requests and faxed to 1-844-403-1029.