

Special Authorization Request Form, for:

TEZSPIRE (tezepelumab)

The purpose of this form is to obtain medical information required to assess your request for a drug on the Special Authorization (SA) list of the Reformulary. Please ensure that all information, including contact information, is complete. Completing this form is not a guarantee of approval.

PART 1: COMPLETE THIS INFORMATION

Information about plan member

First name: _____ Last name: _____

Group number: _____ Certificate number: _____

Date of birth (DD/MM/YY): _____ Gender: _____

Address: _____

City/Town: _____ Province: _____ Postal code: _____

Email: _____ Phone: _____

COORDINATION OF BENEFITS

Coverage through another health benefit plan or provincial plan

Do you or your dependents have drug coverage through another health benefits, insurance company or provincial plan? Yes No

If yes, provide the following: Name of plan member: _____

Policy/Plan number: _____ Certificate number: _____

Patient assistance program

Have you enrolled in a patient assistance program? Yes No

If yes, provide your patient assistance program ID number: _____

Provide the patient assistance program:

Contact name: _____ Phone: _____

PART 2: TO BE COMPLETED BY YOUR DOCTOR (PHYSICIAN)

Physician Information

First name: _____ Last name: _____

License: _____ Phone: _____

Address: _____

City/Town: _____ Province: _____ Postal code: _____

Physician's signature: _____

(confirming the below information to be correct)

Drug being requested through Special Authorization

New request Request for continuation of therapy

DIN: _____ Product name: _____

Strength: _____ Dosage: _____

Site of Administration

Home Private clinic Hospital
 Doctor's office Cancer centre LTC facility

CLINICAL INFORMATION

Diagnosis

Severe asthma

Physician specialty

Allergy specialist
 Clinical immunologist
 Respiriologist

CLINICAL INFORMATION (cont.)

Criteria for initial coverage for Severe asthma, confirm the following:

- Patient is 12 years of age or older; and
- Patient diagnosed with severe asthma; and
- Patient has inadequate control of asthma symptoms after a minimum of 3 months of use with high dose inhaled glucocorticoid and one or more additional asthma controllers (e.g., long-acting beta2-agonist or leukotriene-receptor antagonist); and
- Patient has experienced two or more clinically significant asthma exacerbations in the past 12 months requiring hospitalization, emergency medical care or mechanical ventilation; and
- Tezepelumab is not used in combination with other biologics for the management of severe asthma

NOTE: Duration of initial approval is 1 year

Request for continuation of therapy, confirm the following:

SEVERE ASTHMA: DISCONTINUATION CRITERIA

- Discontinue if 12 month asthma control questionnaire score has not improved from baseline, when baseline represents the initiation of treatment, or
- Discontinue if asthma control questionnaire score achieved after the first 12 months of therapy has not been maintained subsequently, or
- Discontinue if number of clinically significant asthma exacerbations has increased within the previous 12 months, or
- Discontinue in patients on maintenance treatment with oral corticosteroids, there has not been at least a 50% reduction in dose of the oral corticosteroid in the first 12 months of treatment, or
- Discontinue in patients on maintenance treatment with oral corti-costeroids (OCS), the reduction in the dose of OCS achieved after the first 12 months of treatment is not maintained subsequently

NOTE: Duration of continued approval is 1 year

SPECIAL NOTES

Thymic stromal lymphopietin (TSLP) may be involved in the immunological response to some helminth infections. Patients with pre-existing helminth infections should be treated before initiating therapy with tezepelumab.

Describe any intolerances to therapy: _____

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

Date: December 2023