

# TEZSPIRE TOGETHER ENROLLMENT FORM GUIDE

## Streamlining TEZSPIRE Together Enrollment

TEZSPIRE Together can help your patients start and continue on therapy as prescribed by providing support throughout their treatment journey.

This overview can help you streamline the enrollment process by completing the TEZSPIRE Together Enrollment Program Form and submitting it via [TEZSPIRETogetherHCP.com](https://TEZSPIRETogetherHCP.com) or fax to **1-888-388-6016**.

## INDICATION

TEZSPIRE is indicated for the add-on maintenance treatment of adult and pediatric patients aged 12 years and older with severe asthma.

TEZSPIRE is not indicated for the relief of acute bronchospasm or status asthmaticus.

## IMPORTANT SAFETY INFORMATION

### CONTRAINDICATIONS

Known hypersensitivity to tezepelumab-ekko or excipients.

### WARNINGS AND PRECAUTIONS

#### Hypersensitivity Reactions

Hypersensitivity reactions were observed in the clinical trials (eg, rash and allergic conjunctivitis) following the administration of TEZSPIRE. Postmarketing cases of anaphylaxis have been reported. These reactions can occur within hours of administration, but in some instances have a delayed onset (ie, days). In the event of a hypersensitivity reaction, consider the benefits and risks for the individual patient to determine whether to continue or discontinue treatment with TEZSPIRE.

**Please see additional Important Safety Information throughout.**

## 1 Patient Information

Have your patient or their legal representative complete the Patient Information in Section 1.

NOTE: The shipping address is required only for patients who are prescribed the pre-filled pen.

Your patient must read, sign, and date the Patient Authorization on page 5 as a requirement of enrollment in TEZSPIRE Together.

To request Fast Start, your patient must read and accept the program Terms & Conditions on pages 5-6.

To enroll in the co-pay program, your patient must answer the eligibility question and read and accept the program Terms & Conditions on pages 6-7.

**TEZSPIRE®** (tezepelumab-ekko) Subcutaneous Injection 210 mg **TEZSPIRE® together** **Program Enrollment Form**

THIS SECTION TO BE COMPLETED AND SIGNED BY THE PATIENT OR LEGAL REPRESENTATIVE

**1 PATIENT INFORMATION** An asterisk (\*) indicates a required field.

First Name: **Thomas** Last Name: **Tezspire**

Date of Birth: **06 / 02 / 1979** Sex: ☒ Male ☐ Female ☐ Not Specified

Street: **123 Main Street** City: **Chicago** State: **IL** ZIP Code: **12345**

If you are approved for the TEZSPIRE pre-filled pen for self-administration, your TEZSPIRE prescription will be shipped to you. Please provide your shipping address if different than the above address.

Street: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP Code: \_\_\_\_\_

We use text or email to send necessary communications regarding our programs, including co-pay card details (if eligible). If these options are not available, we will send communications through direct mail.

Email: **tommytezspire@example.com** Phone: **(123) 456-7890** ☐ Home ☒ Mobile

Preferred Language (if not English): \_\_\_\_\_ Preferred Form of Communication: ☒ Text ☐ Email

**\*TELEPHONE CONSUMER PROTECTION ACT (TCPA) CONSENT (REQUIRED FOR TEXT COMMUNICATIONS ONLY)**

☐ In addition to the below patient authorization consent, I understand that by checking this box and signing below, I consent to Amgen and AstraZeneca calling and texting me at the phone number(s) I have provided with promotional communications relating to Amgen and AstraZeneca products and services and/or my condition or treatment. Amgen and AstraZeneca may use automatic dialing machines or artificial or prerecorded messages to contact me and may leave a voicemail or SMS/text message (standard text messaging rates may apply). I understand that I am not required to provide this consent as a condition of purchasing any goods or services. Reply STOP to cancel SMS messages.

**PATIENT AUTHORIZATION**

I have read and agree to the Authorization to Use and Disclose Personal Information on page 5. You must sign below to participate in the TEZSPIRE Together Fast Start and Co-pay Card Programs. Legal representative is required if patient is younger than 18 years of age.

Signature of Patient/Legal Representative: **Thomas Tezspire** Name of Patient/Legal Representative: **Thomas Tezspire** Today's Date: **02 / 15 / 2023**

Legal Representative Phone (if different from above): \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

**TEZSPIRE TOGETHER FAST START PROGRAM TERMS & CONDITIONS (COMMERCIALY INSURED PATIENTS ONLY)**

If you have commercial insurance and your health plan requires a prior authorization or does not cover TEZSPIRE (pre-filled syringe only), you may be eligible to receive TEZSPIRE free for up to twelve (12) doses within twenty-four (24) months from the date the first dose is filled. See full Terms & Conditions on pages 5-6.

☒ By checking this box, I agree that I have read, understand, and accept the Terms & Conditions of the Fast Start Program on pages 5-6.

**TEZSPIRE TOGETHER CO-PAY PROGRAM TERMS & CONDITIONS (COMMERCIALY INSURED PATIENTS ONLY)**

To check eligibility for the Co-pay Card Program, you must have commercial insurance and you must answer the question below, agree to the Terms & Conditions, and sign the Patient Authorization above.

Are you eligible for Medicare but receive prescription drug coverage from a former employer, union, or welfare plan?: ☐ Yes ☒ No ☐ I don't know

☒ By checking this box, I agree that I have read, understand, and accept the Terms & Conditions of the Co-pay Card Program on pages 6-7.

Please see Indication and Important Safety Information on Page 8.

Please COMPLETE and FAX pages 1-4 to 1-888-388-6016. For additional assistance, CALL 1-888-TEZSPIRE (1-888-897-7473). 8 a.m. - 8 p.m. ET, Monday - Friday. Please visit [TEZSPIREtogetherHCP.com](https://tezspiretogetherHCP.com) for additional resources.

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The most frequently missing fields of information are patient consent, Site NPI, and insurance details. Please ensure these fields are complete.

## IMPORTANT SAFETY INFORMATION

### WARNINGS AND PRECAUTIONS

#### Acute Asthma Symptoms or Deteriorating Disease

TEZSPIRE should not be used to treat acute asthma symptoms, acute exacerbations, acute bronchospasm, or status asthmaticus.

Please see additional Important Safety Information throughout.

## 2 Insurance Information

Check your patient's insurance type and provide both primary medical and pharmacy insurance information.

The patient will also be required to provide front and back copies of all insurance cards.

## 3 Product Selection & Acquisition

Check your primary and secondary formulation preference for TEZSPIRE.

- Select TEZSPIRE pre-filled syringe for HCP administration or pre-filled pen for self-administration
- If you are unsure which to select as your primary option, check the TEZSPIRE pre-filled syringe, and TEZSPIRE Together will run a benefit verification to determine the option(s) for your patient
- For pre-filled syringe only, indicate how you plan to obtain TEZSPIRE, via Buy and Bill or through a Specialty Pharmacy

**TEZSPIRE®** (tezepelumab-ekko) Subcutaneous Injection 210 mg | **TEZSPIRE® together** | **Program Enrollment Form**

Patient First Name: Thomas | Patient Last Name: Tezspire | Patient Date of Birth: 06 / 02 / 1979

**THIS PAGE TO BE COMPLETED BY A HEALTHCARE PROFESSIONAL**

### 2 INSURANCE INFORMATION

An asterisk (\*) indicates a required field.

☒ Commercial/Private Insurance ☐ Medicare/Medicaid/TRICARE ☐ Uninsured

\*Please complete both primary medical insurance and pharmacy insurance information and provide front and back copies of all medical and prescription insurance cards.  
If your patient is uninsured, please ask them to call 1-888-897-7473 to determine if they qualify for assistance through the TEZSPIRE Patient Assistance Program.

| Primary Medical Insurance            |                | Pharmacy Insurance           |  | Secondary Medical Insurance |
|--------------------------------------|----------------|------------------------------|--|-----------------------------|
| Insurance Provider                   | Anthem         | CVS Caremark                 |  |                             |
| Insurance Phone                      | (800) 123-1234 | (800) 234-5678               |  |                             |
| Cardholder Name (if not the patient) |                |                              |  |                             |
| Cardholder Date of Birth             | 06/02/1979     | 06/02/1979                   |  |                             |
| Policy ID                            | 111111         | 222222                       |  |                             |
| Group #                              | 123123A        | 45678TT                      |  |                             |
| RxBIN/RPCN                           | X              | RxBIN: 34567<br>RPCN: 891011 |  | X                           |

### 3 PRODUCT SELECTION & ACQUISITION

TEZSPIRE is available in 2 formulations, a pre-filled syringe for HCP administration and a pre-filled pen for self-administration.

**Please select the primary and secondary formulation preference.**

**Primary Option:** ☐ Pre-filled syringe (HCP administration) ☒ Pre-filled pen (self-administration)

**Secondary Option:** ☒ Pre-filled syringe (HCP administration) ☐ Pre-filled pen (self-administration) ☐ Do not pursue a second option

**Please answer the questions below if you have a preference for the pre-filled syringe formulation.**

**How will you obtain TEZSPIRE pre-filled syringe?** ☐ Buy & Bill ☒ Specialty Pharmacy

**Preferred Specialty Pharmacy** CVS Specialty

**Where will your patient receive their injections?** ☐ Healthcare Provider Office ☐ Hospital Outpatient/Infusion Center ☒ N/A

Please see Indication and Important Safety Information on Page 8.  
Please COMPLETE and FAX pages 1-4 to 1-888-388-6016. For additional assistance, CALL 1-888-TEZSPIRE (1-888-897-7473).  
8 a.m. - 8 p.m. ET, Monday - Friday. Please visit [TEZSPIREtogetherHCP.com](http://TEZSPIREtogetherHCP.com) for additional resources.

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Don't forget to complete the primary medical insurance and pharmacy insurance information to avoid processing delays.

## IMPORTANT SAFETY INFORMATION

### WARNINGS AND PRECAUTIONS

#### Abrupt Reduction of Corticosteroid Dosage

Do not discontinue systemic or inhaled corticosteroids abruptly upon initiation of therapy with TEZSPIRE. Reductions in corticosteroid dose, if appropriate, should be gradual and performed under the direct supervision of a physician. Reduction in corticosteroid dose may be associated with systemic withdrawal symptoms and/or unmask conditions previously suppressed by systemic corticosteroid therapy.

Please see additional Important Safety Information throughout.

## 4 Program Services

Check the services you would like TEZSPIRE Together to provide.

- Benefits Verification
- Transfer to Specialty Pharmacy
- Prior Authorization and Appeals Support
- Co-pay Program\*
- Fast Start Program\*

NOTE: You can always add services at a later date via [TEZSPIREtogetherHCP.com](https://TEZSPIREtogetherHCP.com) or by calling 1-888-TZSPIRE (1-888-897-7473)

## 5 Clinical Information

Provide your patient's medical history, including the diagnosis code and known drug allergies.

*Clinical notes and additional documentation are **NOT** required to process a patient benefit verification. Please **DO NOT** provide anything beyond the information requested of this form as review of clinical documentation sent to TEZSPIRE Together could delay response time back to the office.*

## 6 Prescriber Information

Complete the Prescriber Information for your practice, including your primary office contact, in case questions arise regarding a patient's enrollment.

NOTE: If submitting for a Medicare patient, please provide PTAN #. If submitting for a Medicaid patient, please provide Medicaid Provider #.

**TEZSPIRE®** (tezepelumab-ekko) Subcutaneous Injection 210 mg

**TEZSPIRE® together**

**Program Enrollment Form**

Patient First Name: **Thomas** Patient Last Name: **Tezspire** Patient Date of Birth: **06 / 02 / 1979**

THIS PAGE TO BE COMPLETED BY A HEALTHCARE PROFESSIONAL

**4 PROGRAM SERVICES** An asterisk (\*) indicates a required field.

**TEZSPIRE Together Service Request (check all that apply):**

- ☐ **Benefits Verification:** Verify your patient's insurance coverage for TEZSPIRE. TEZSPIRE Together will run a Benefits Verification for the preferred formulation. In the event the preferred formulation is not covered, a Benefits Verification will be run for the second option, if applicable.
- ☐ **Transfer to Specialty Pharmacy:** TEZSPIRE Together will transfer your patient's prescription to the preferred or mandated Specialty Pharmacy. Please complete Section 7 and ensure the Pharmacy Insurance Information is completed in Section 2.
- ☐ **Prior Authorization (PA) and Appeals Support:** Identify the PA and appeal requirements based on plan criteria and track the status of a submission.
- ☐ **Co-pay Program:** Help your eligible commercially insured patients enroll in the TEZSPIRE Together Co-pay Program and reduce their out-of-pocket costs for both TEZSPIRE medication and HCP administration. Please ensure the patient has agreed to the Co-pay Program Terms and Conditions on page 1.
- ☐ **Fast Start Program:** The Fast Start Program provides up to 12 doses of the pre-filled pen or pre-filled syringe at no cost to eligible commercially insured patients whose plan requires a PA or does not cover TEZSPIRE (pre-filled syringe only). For immediate enrollment in Fast Start, please complete the Fast Start Prescription in Section 7, check the box for Fast Start, and confirm the patient has completed Section 1. By checking this box, I acknowledge that the PA must be submitted within 30 days of the first Fast Start shipment. Additionally, if the PA is denied, an appeal must be submitted within 30 days of denial. Noncompliance with these terms will result in the patient no longer being eligible for the Fast Start Program. If the patient's insurance plan releases a written policy for TEZSPIRE after a PA or appeal was previously submitted, a new PA must be submitted within 30 days of notification of policy change to remain eligible for the program.

Please provide the address to which the Fast Start pre-filled syringe (HCP administration) should be shipped if different than the prescriber's address in Section 6. Fast Start doses of the pre-filled pen for self-administration will be shipped to the patient's address provided on page 1.

Site Name: \_\_\_\_\_ Site NPI: \_\_\_\_\_  
Street: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP Code: \_\_\_\_\_

**5 CLINICAL INFORMATION**

ICD-10-CM Code: ☐ J45.50 Severe persistent asthma, uncomplicated ☐ J45.51 Severe persistent asthma with (acute) exacerbation ☐ Other/Misc: \_\_\_\_\_

Known Drug Allergies: \_\_\_\_\_

**6 PRESCRIBER INFORMATION**

Prescriber Name: **Dr. Mary Smith** Office Contact Name: **Jo Diaz**  
Prescriber NPI #: **1122334455** Office Contact Email: **jo.diaz@example.com**  
Site NPI #: **6677889910** Practice/Clinic Name: **Allergy Medical Associates**  
Tax ID #: **12-45678**  
Street: **1001 S. State Street** City: **Chicago** State: **IL** ZIP Code: **12345**  
Medicare Provider # (PTAN): **654321** Phone: **(800) 800-1001** Fax: **(800) 800-1002**  
Medicaid Provider #: \_\_\_\_\_

Please see Indication and Important Safety Information on Page 8.  
Please **COMPLETE** and **FAX** pages 1-4 to **1-888-388-6016**. For additional assistance, **CALL 1-888-TZSPIRE (1-888-897-7473)**.  
8 a.m. - 8 p.m. ET, Monday - Friday. Please visit [TEZSPIREtogetherHCP.com](https://TEZSPIREtogetherHCP.com) for additional resources.

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\*The patient must agree to program Terms & Conditions on page 1. Eligibility criteria and program maximums apply.

## IMPORTANT SAFETY INFORMATION WARNINGS AND PRECAUTIONS

### Parasitic (Helminth) Infection

It is unknown if TEZSPIRE will influence a patient's response against helminth infections. Treat patients with pre-existing helminth infections before initiating therapy with TEZSPIRE. If patients become infected while receiving TEZSPIRE and do not respond to anti-helminth treatment, discontinue TEZSPIRE until infection resolves.

**Please see additional Important Safety Information throughout.**

## 7 Prescription Information


Write the pharmacy prescription if you selected TEZSPIRE pre-filled pen or the pre-filled syringe via Specialty Pharmacy in Section 3.



Read the Prescriber Attestation.

Sign and date the appropriate signature field.

Commercial patients only:  
Write the Fast Start prescription for both first and second formulation preference if you checked this service in Section 4.

Sign and date the appropriate signature field.





**Program Enrollment Form**

Patient First Name: **Thomas**

Patient Last Name: **Tezspire**

Patient Date of Birth: **06 / 02 / 1979**

THIS PAGE TO BE COMPLETED BY A HEALTHCARE PROFESSIONAL

### 7 PRESCRIPTION INFORMATION

An asterisk (\*) indicates a required field.

**Please complete the pharmacy and Fast Start prescription(s) for your first and second preference, if applicable.** If you have requested transfer of the prescription to a Specialty Pharmacy, TEZSPIRE Together will transfer the prescription for the first preference if coverage is available. If coverage for the first preference is not available, the prescription for the second preference will be transferred.

**SPECIALTY PHARMACY PRESCRIPTION**

☒ **TEZSPIRE (tezpelumab-ekko)** 210 mg/1.91 mL (110 mg/mL) single-dose pre-filled syringe injection

SIG: Inject 210 mg SC once every 4 weeks  
HCP Administration (NDC: 55513-112-01)  
Quantity Dispensed: \* 1    Refills: \*

SIG: Inject 210 mg SC once every 4 weeks as directed by physician  
Self-Administration (NDC: 55513-0123-01)  
Quantity Dispensed: \* 1    Refills: \*    

I authorize Amgen Inc., its affiliates, agents, and contractors (collectively, "Amgen") to transmit the above prescription by any means allowed under applicable law to the preferred Specialty Pharmacy (identified above) for my patient unless the patient's payer mandates a different Specialty Pharmacy for my patient.

**Prescriber Attestation:** If TEZSPIRE is shipped to the prescriber's office, the prescriber accepts TEZSPIRE on behalf of the patient for administration in the office. The prescriber is to comply with his/her state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Noncompliance with state-specific requirements could result in outreach to the prescriber.

By signing below, I certify as a licensed healthcare professional that the patient named on this form has, or has had, a diagnosis for an FDA-approved indication for TEZSPIRE. I also certify that this is my legal signature.

CA, MA, NC & PR: Interchange is mandated unless the prescriber writes the words "No Substitution". \_\_\_\_\_  
NY & IA providers: please submit electronic prescription.

Dispense as Written/Brand Medically Necessary/Do Not Substitute/No Substitution/May Not Substitute

Prescriber Signature (dispense as written): Mary Smith

Today's Date: 02/15/23

May Substitute/Product Selection Permitted/Submission Permissible

Prescriber Signature (substitution permitted): \_\_\_\_\_

Today's Date: \_\_\_\_\_

**FAST START PRESCRIPTION**

Fast Start is an optional program that provides up to 12 free doses of TEZSPIRE to eligible commercially insured patients whose plan requires a PA or does not cover TEZSPIRE (pre-filled syringe only).

☒ **TEZSPIRE (tezpelumab-ekko)** 210 mg/1.91 mL (110 mg/mL) single-dose pre-filled syringe injection

SIG: Inject 210 mg SC once every 4 weeks  
HCP Administration (NDC: 55513-112-01)  
Quantity Dispensed: \* 1    Refills: \* 11

SIG: Inject 210 mg SC once every 4 weeks as directed by physician  
Self-Administration (NDC: 55513-0123-01)  
Quantity Dispensed: \* 1    Refills: \* 11

Dispense as Written/Brand Medically Necessary/Do Not Substitute/No Substitution/May Not Substitute

Prescriber Signature (dispense as written): Mary Smith

Today's Date: 02/15/23

Dispense as Written/Brand Medically Necessary/Do Not Substitute/No Substitution/May Not Substitute

Prescriber Signature (dispense as written): \_\_\_\_\_

Today's Date: \_\_\_\_\_

May Substitute/Product Selection Permitted/Submission Permissible

Prescriber Signature (substitution permitted): \_\_\_\_\_

Today's Date: \_\_\_\_\_

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Please see Indication and Important Safety Information on Page 8.

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**Double check the form for any missing information or signatures, and fax pages 1-4 to 1-888-388-6016. Please ensure your patient retains pages 5-7.**

## Let's do this Together.

If you have additional questions about TEZSPIRE Together or the enrollment process, connect with a dedicated specialist at [TEZSPIRETogetherHCP.com](https://tezspiretogetherhcp.com) or call **1-888-TZSPIRE (1-888-897-7473)**, 8 AM - 8 PM ET, Monday - Friday.

## IMPORTANT SAFETY INFORMATION

### WARNINGS AND PRECAUTIONS

#### Live Attenuated Vaccines

The concomitant use of TEZSPIRE and live attenuated vaccines has not been evaluated. The use of live attenuated vaccines should be avoided in patients receiving TEZSPIRE.

**Please see additional Important Safety Information on the last page.**

# IMPORTANT SAFETY INFORMATION

## CONTRAINDICATIONS

Known hypersensitivity to tezepelumab-ekko or excipients.

## WARNINGS AND PRECAUTIONS

### Hypersensitivity Reactions

Hypersensitivity reactions were observed in the clinical trials (eg, rash and allergic conjunctivitis) following the administration of TEZSPIRE. Postmarketing cases of anaphylaxis have been reported. These reactions can occur within hours of administration, but in some instances have a delayed onset (ie, days). In the event of a hypersensitivity reaction, consider the benefits and risks for the individual patient to determine whether to continue or discontinue treatment with TEZSPIRE.

### Acute Asthma Symptoms or Deteriorating Disease

TEZSPIRE should not be used to treat acute asthma symptoms, acute exacerbations, acute bronchospasm, or status asthmaticus.

### Abrupt Reduction of Corticosteroid Dosage

Do not discontinue systemic or inhaled corticosteroids abruptly upon initiation of therapy with TEZSPIRE. Reductions in corticosteroid dose, if appropriate, should be gradual and performed under the direct supervision of a physician. Reduction in corticosteroid dose may be associated with systemic withdrawal symptoms and/or unmask conditions previously suppressed by systemic corticosteroid therapy.

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### Live Attenuated Vaccines

The concomitant use of TEZSPIRE and live attenuated vaccines has not been evaluated. The use of live attenuated vaccines should be avoided in patients receiving TEZSPIRE.

## ADVERSE REACTIONS

The most common adverse reactions (incidence  $\geq 3\%$ ) are pharyngitis, arthralgia, and back pain.

## USE IN SPECIFIC POPULATIONS

There are no available data on TEZSPIRE use in pregnant women to evaluate for any drug-associated risk of major birth defects, miscarriage, or other adverse maternal or fetal outcomes. Placental transfer of monoclonal antibodies such as tezepelumab-ekko is greater during the third trimester of pregnancy; therefore, potential effects on a fetus are likely to be greater during the third trimester of pregnancy.

**Full Prescribing Information including Patient Information and Instructions for Use.**

***You may report side effects related to AstraZeneca products by clicking [here](#).***

TEZSPIRE is a registered trademark of Amgen Inc. and AstraZeneca.

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