Mountain-Pacific Quality Health
Partnering within our communities to provide solutions for better health
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Montana Healthcare Programs Prior Authorization Request Form for Use of ADBRY® (tralokinumab)

Member Name:	DOB:	Date:
Member ID:	Prescriber Phone:	
Prescriber Name/Specialty if applicable:	Prescriber Fax:	
Dosage Requested:		

Please complete below information for applicable situation, <u>Initiation</u> or <u>Continuation</u> of therapy:

☐ INITIATION OF THERAPY

Member must meet all of the following criteria:

1. Member has a diagnosis of moderate to severe atopic dermatitis: ☐ Yes ☐ No
2. Member is ≥ 18 years of age: ☐ Yes ☐ No
3. Member has clinical documentation of <u>functional impairment</u> due to atopic dermatitis, which may include, but is not limited to, limitations to activities of daily living (ADLs), such as skin infections or sleep disturbances and a baseline assessment has been made to allow for documentation of positive clinical response. ☐ Yes ☐ No
4. Member must have had an inadequate treatment response, intolerance, or contraindication to <u>all</u> of the following (in listed order).
   - A preferred moderate to very high-potency topical corticosteroid ☐ Yes ☐ No

     Name: _____ Dates: _____

   - A topical immunomodulator (Elidel® or Protopic®) ☐ Yes ☐ No

     Name: _____ Dates: _____

   <u>NOTE</u>: Inadequate treatment response to topical therapy is defined as failure to achieve and maintain remission or a low disease activity state despite treatment with a daily regimen, applied for ≥ 28 days or for the maximum duration recommended by the product prescribing information (e.g., 14 days for high or very-high potency topical corticosteroids).

5. Provider attests that member <u>WILL NOT</u> use Adbry in combination with therapeutic biologics, other Janus kinase inhibitors, or potent immunosuppressants such as azathioprine or cyclosporine: ☐ Yes ☐ No

<u>LIMITATIONS</u>:

Maximum dose for initial authorization: 600mg (4 x 150mg syringe) initial dose, then 300mg (2 x 150mg syringe) every 2 weeks.

Initial authorization will be issued for 6 months.

☐ **CONTINUATION OF THERAPY**

1. Member has documentation of positive clinical response to ADBRY® therapy (e.g. reduction in body surface area involvement, reduction in pruritus severity or decrease in severity index using a scoring tool)?
   ☐ Yes ☐ No

LIMITATIONS:

Maximum dose for continuation of therapy: 300mg (2 x 150mg syringe) every 2 weeks

Reauthorization will be issued for 12 months.

Please complete form, including required attachments and fax to:
Drug Prior Authorization Unit @ 1-800-294-1350

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