Montana Healthcare Programs Prior Authorization Request Form for Use of ADBRY® (tralokinumab)

Member Name: _________________________  Date: _________________

Member ID: _________________________  Prescriber Phone: _________________________

Prescriber Name/Specialty if applicable: _________________________  Prescriber Fax: _________________________

Dosage Requested: _________________________

Please complete below information for applicable situation, Initiation or Continuation 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 functional impairment 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 all 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: _________________

NOTE: 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 WILL NOT use Adbry in combination with therapeutic biologics, other Janus kinase inhibitors, or potent immunosuppressants such as azathioprine or cyclosporine: □ Yes □ No

LIMITATIONS:

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

06/2022