Mountain Pacific
INNOVATING 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, Initiation or Continuation of therapy:

☐ INITIATION OF THERAPY

Member must meet all the following criteria:

1. Member has a diagnosis of moderate to severe atopic dermatitis: ☐ Yes ☐ No
2. Member is >12 years of age: ☐ Yes ☐ No
3. (*Applies only to members less than 18 years of age)* Medication is prescribed by or in consultation with a dermatology specialist: ☐ Yes ☐ No

   Action required: If not in a specialty clinic or written by a specialist, copy of annual specialty consult with an appropriate specialist is required (please attach copy of consult):

   Name of specialist: _____ **Contact date:** _____
4. 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
5. Member must have had an inadequate treatment response, intolerance or contraindication to **all** the following:

   A preferred, age-appropriate, topical steroid: ☐ 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).
6. Member has trialed and has had an inadequate treatment response, intolerance or contraindication to a preferred drug with the same indication from the Montana Healthcare Programs Preferred Drug List 19 (mt.gov) (unless preferred product(s) do not have the appropriate indication): ☐ Yes ☐ No

7. Provider attests baseline assessment has been made to allow for documentation of positive clinical response: ☐ Yes ☐ No
8. Provider attests member **will not** use Adbry® concomitantly with other biologics: ☐ Yes ☐ No

LIMITATIONS:

- Maximum dose for initial authorization for adults: 600mg (4 x 150mg syringe) initial dose, then 300mg (2 x 150mg syringe) every other week
- Maximum dose for initial authorization for 12 to 17 years of age: 300mg (2 x 150mg syringe) initial dose, then 150mg (1 x 150mg syringe) every other week

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
2. Annual specialist consult attached if prescriber is not a specialist: ☐ Yes ☐ No ☐ N/A – prescriber is a specialist.
3. Provider attests member **will not** use Adbry® concomitantly with other biologics: ☐ Yes ☐ No

LIMITATIONS:

- Maximum dose for renewal authorization for adults: 300mg (2 x 150mg syringe) every other week
- Maximum dose for renewal authorization for 12 to 17 years of age: 150mg (1 x 150mg syringe) every other week

Reauthorization will be issued for 12 months.

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