carolina complete health

Monoclonal Antibodies: Adbry

Beneficiary Information

1. Beneficiary Last Name: _____ 2. First Name: _____

3. Beneficiary ID #: _____ 4. Beneficiary Date of Birth: _____ 5. Beneficiary Gender: _____

Prescriber Information

6. Prescribing Provider NPI #: _____

7. Requester Contact Information - Name: _____ Phone #: _____ Ext. _____

Drug Information

8. Drug Name:_____ 9. Strength: _____ 10. Quantity Per 30 Days: _____

11. Length of Therapy (in days): ☐ up to 30 Days ☐ 60 Days ☐ 90 Days ☐ 120 Days ☐ 180 Days ☐ 365 Days ☐ Other _____

Clinical Information

Initial Approval:

1. Is the beneficiary age 18 years of age or older? ☐ **Yes** ☐ **No**
2. Will the beneficiary receive live vaccines during Adbry therapy? ☐ **Yes** ☐ **No**
3. Does the beneficiary have a diagnosis of moderate to severe Atopic Dermatitis? ☐ **Yes** ☐ **No**
4. Does the beneficiary have at least 1 of the following? ☐ **Yes** ☐ **No Please indicate which one(s).**_____
   a. Involvement of at least 10% of body surface
   b. area (BSA); Eczema Area and Severity Index (EASI) score of 16 or greater
   c. Investigator's Global Assessment (IGA) score of 3 or more
   d. Scoring Atopic Dermatitis (SCORAD) score of 25 or more
   e. Incapacitation due to AD lesion location (i.e.,head and neck, palms, soles, or genitalia)
5. Has the beneficiary had a trial and failure of at least 2 prescription topical steroids or have a documented adverse reaction or contraindication that precludes trial of at least 2 prescription topical steroids? ☐ **Yes** ☐ **No**

Please list _____

6. Has the beneficiary had a trial and failure or documented adverse reaction or contraindication that precludes use of one of the following?

☐ **Yes** ☐ **No Please indicate which one(s).**_____

   a. Topical calcineurin inhibitor (e.g., pimecrolimus or tacrolimus)
   b. Topical phosphodiesterase-4 inhibitor (e.g., crisaborole)
   c. Topical Janus kinase inhibitor (e.g., ruxolitinib)
7. Will tralokinumab-ldrm (Adbry) be used in combination with other monoclonal antibody biologics (e.g., tezepelumab, omalizumab, mepolizumab, reslizumab, benralizumab, dupilumab)? ☐ **Yes** ☐ **No**

Initial approval can be for up to 16 weeks

For continuation of therapy, please answer questions 1-9

8. While on Adbry, has the beneficiary had disease improvement and/or stabilization from baseline supported by medical records? ☐ **Yes** ☐ **No**
9. Has the beneficiary experienced any serious treatment-related adverse events(e.g., serious infection, conjunctivitis, keratitis, eosinophilia)?☐ **Yes**☐**No**

Reauthorizations can be for up to 6 months

** Please provide medical records documenting the beneficiary's current Atopic Dermatitis status and response to Adbry treatment**

Signature of Prescriber:_____ Date:_____

(Prescriber Signature Mandatory)

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to: (833) 404-2393 Pharmacy PA Call Center: (833) 585-4309

https://www.covermymeds.com/main/prior-authorization-forms/