# AvMed

## PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

**Directions**: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-305-671-0200**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

**Drug Requested: Adbry®** (tralokinumab)

**MEMBER & PRESCRIBER INFORMATION:** Authorization may be delayed if incomplete.

**Member Name:** _____

**Member AvMed #:** _____ **Date of Birth:** _____

**Prescriber Name:** _____

**Prescriber Signature:** _____ **Date:** _____

**Office Contact Name:** _____

**Phone Number:** _____ **Fax Number:** _____

**DEA OR NPI #:** _____

**DRUG INFORMATION:** Authorization may be delayed if incomplete.

**Drug Name/Form/Strength:** _____

**Dosing Schedule**: _____ **Length of Therapy**: _____

**Diagnosis:** _____ **ICD Code, if applicable:** _____

**Weight:** _____ **Date:** _____

**Quantity Limits:** 4 mL (4 prefilled syringes) per 28 days

**Recommended Dosage:** 600 mg (given as four 150 mg injections) once, followed by 300 mg (given as two 150 mg injections) once every other week. In members with body weight <100 kg who achieve clear or almost clear skin after 16 weeks of therapy, may reduce dosage to 300 mg every 4 weeks.

**NOTE: The Health Plan considers the use of concomitant therapy with Adbry®, Cinqair®, Dupixent®, Fasenra®, Nucala®, and Xolair® to be experimental and investigational. Safety and efficacy of these combinations have NOT been established and will NOT be permitted. In the event a member has an active Cinqair®, Dupixent®, Fasenra®, Nucala®, and Xolair® authorization on file, all subsequent requests for Adbry® will NOT be approved.**

**CLINICAL CRITERIA:** Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

**(Continued on next page)**

## ❑ Diagnosis: Moderate-to-Severe Atopic Dermatitis

**Initial Authorization: 4 months**

- ❑ Member has a diagnosis of **moderate to severe atopic dermatitis** with disease activity confirmed by **ONE** of the following **(chart notes documenting disease severity and BSA involvement must be included):**
  - ❑ Body Surface Area (BSA) involvement >10%
  - ❑ Eczema Area and Severity Index (EASI) score ≥ 16
  - ❑ Investigator's Global Assessment (IGA) score ≥ 3
  - ❑ Scoring Atopic Dermatitis (SCORAD) score ≥ 25
- ❑ Prescribed by or in consultation with an **Allergist, Dermatologist** or **Immunologist**
- ❑ Member is 12 years of age or older
- ❑ Member has tried and failed, has a contraindication, or intolerance to **ALL** four of the following therapies **(chart notes documenting contraindication(s) or intolerance must be attached; trials will be verified using pharmacy claims and/or submitted chart notes)**:
  - ❑ 30 days (14 days for very high potency) of therapy with **ONE** medium to very-high potency topical corticosteroid in the past 180 days
  - ❑ 30 days of therapy with **ONE** of the following topical calcineurin inhibitors in the past 180 days:
    - ❑ tacrolimus 0.03 % or 0.1% ointment
    - ❑ pimecrolimus 1% cream **(requires prior authorization)**
  - ❑ 90 days of phototherapy (e.g., NB UV-B, PUVA) unless the member is not a candidate and/or has an intolerance or contraindication to therapy
  - ❑ 90 days of therapy with **ONE** of the following oral immunosuppressants in the past 180 days:
    - ❑ azathioprine
    - ❑ cyclosporine
    - ❑ methotrexate
    - ❑ mycophenolate

**Reauthorization: 12 months.** Check below all that apply. All criteria must be checked for approval. To support each line checked, all documentation (lab results, diagnostics, and/or chart notes) must be provided or request may be denied.

- ❑ Member has experienced a positive clinical response to Adbry® therapy (e.g., reduced BSA involvement, decrease in severity based on physician assessment) **(chart notes must be submitted)**
- ❑ Provider submits clinical documentation to support **ONE** of the following:
  - ❑ Maintenance dosage has been decreased to 300 mg every 4 weeks
  - ❑ Member has tried and failed 180 days of therapy at maintenance dosage of 300 mg every 4 weeks and is no longer experiencing a positive clinical response to Adbry® therapy (e.g., increased BSA involvement, increase in severity based on physician assessment) **(verified by paid claims; chart notes must be submitted)**

**(Continued on next page)**

**Medication being provided by Specialty Pharmacy – Proprium Rx**

***Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.****

**Previous therapies will be verified through pharmacy paid claims or submitted chart notes.***