AmeriHealth Caritas North Carolina

Pharmacy Request for Prior Approval – Adbry

Beneficiary Information

1. Beneficiary Last Name: _____ 2. First Name: _____
3. Beneficiary ID #: _____ 4. Beneficiary Date of Birth: _____ 5. Beneficiary Gender: _____

Prescriber Information

6. Prescriber Name: _____ NPI #: _____
Mailing address: _____ City: _____ State: _____ ZIP: _____
7. Requester Contact Information: _____
Name: _____ Phone #: _____ Fax #: _____

Drug Information

8. Drug Name: _____ 9. Strength: _____ 10. Quantity Per 30 Days: _____
11. Length of Therapy: ___up to 30 days ___60 days ___90 days ___120 days ___180 days ___365 days ___Other:_____

Clinical Information

Initial Approval **Initial approval can be for up to 16 weeks**
1. Is the beneficiary 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:** _____
   a. Involvement of at least 10% of body surface area (BSA)
   b. 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 a 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 the 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___

For continuation of therapy, please answer questions 1-9 **Reauthorizations can be for up to 6 months**
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___

**** 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: 1-877-234-4274, or call Pharmacy Prior Authorization: 1-866-885-1406

12/27/2023