OKLAHOMA Health Care Authority

State of Oklahoma
SoonerCare

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Adbry™ (tralokinumab-ldrm) Prior Authorization Form

Member Name:_____ **Date of Birth:**_____ **Member ID#:**_____

Drug Information

Pharmacy billing (NDC:_____) Fill Date:_____

Dose:_____ Regimen:_____

Pharmacy Information

Pharmacy NPI:_____ Pharmacy Name:_____

Pharmacy Phone:_____ Pharmacy Fax:_____

Prescriber Information

Prescriber NPI:_____ Prescriber Name:_____

Prescriber Phone:_____ Prescriber Fax:_____ Specialty:_____

Clinical Information

For Initial Authorization: (Initial approval will be for the duration of 16 weeks)

1. Diagnosis of moderate-to-severe atopic dermatitis? Yes ☐ No ☐
2. Member's body surface area (BSA) of atopic dermatitis involvement: _____
3. Is member inadequately controlled with topical prescription therapies? Yes☐ No☐
4. Is there a reason topical treatment is not advised? Yes☐ No☐
   i. If yes, please describe: _____
5. Has the member failed 1 medium potency to very-high potency Tier-1 topical corticosteroid? Yes☐ No☐
   i. If yes, please provide the medication and duration of treatment:
      a. Drug:_____ Date of trial:_____
      b. Was the trial at least 2 weeks in duration? Yes☐ No☐
   ii. If no, is there a contraindication or documented intolerance to medium potency to very-high potency Tier-1 topical corticosteroids? Yes☐ No☐
      a. If yes, please describe:_____
6. Has the member failed 1 topical calcineurin inhibitor (e.g., pimecrolimus or tacrolimus)? Yes☐ No☐
   i. If yes, please provide the medication and duration of treatment:
      a. Drug:_____ Date of trial:_____
      b. Was the trial at least 2 weeks in duration? Yes☐ No☐
   ii. If no, is there a contraindication or documented intolerance to topical calcineurin inhibitors? Yes☐ No☐
      a. If yes, please describe:_____
7. Will the member be using Adbry™ concurrently with other biologic medications? Yes☐ No☐
   i. If yes, please provide patient-specific information to support the concurrent use of medications:
   _____
8. Has the member been evaluated by an allergist, dermatologist or immunologist within the last 12 months (or an advanced care practitioner with a supervising physician who is one of these specialties)? Yes☐ No☐
   i. If yes, please include name of specialist: _____ Specialty:_____

For Continued Authorization:

1. Is member compliant with therapy? Yes☐ No☐
2. Is member responding well to therapy? Yes☐ No☐

Please do not send in chart notes. Specific information/documentation will be requested if necessary.
Please complete and return <u>all</u> pages. Failure to complete all pages will result in processing delays.

Prescriber Signature:_____ **Date:**_____
By signature, the physician confirms the criteria information above is accurate and verifiable in patient records.)

Fax completed prior authorization request form to 888-601-8461 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts. All requesteddata must be provided. Incomplete forms or forms without the chart notes will be returned. Pharmacy Coverage Guidelines are available at AetnaBetterHealth.com/Oklahoma.