

**Ebglyss™ (Ilebrikizumab-Ibkz) Prior Authorization Form**

Member Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Member ID#: \_\_\_\_\_

**Drug Information**

Pharmacy Billing (NDC: \_\_\_\_\_) Start Date (or date of next dose): \_\_\_\_\_

Dose: \_\_\_\_\_ Regimen: \_\_\_\_\_

**Pharmacy Information**

Pharmacy NPI: \_\_\_\_\_ Pharmacy Name: \_\_\_\_\_

Pharmacy Phone: \_\_\_\_\_ Pharmacy Fax: \_\_\_\_\_

**Prescriber Information**

Prescriber NPI: \_\_\_\_\_ Prescriber Name: \_\_\_\_\_

Prescriber Phone: \_\_\_\_\_ Prescriber Fax: \_\_\_\_\_ Specialty: \_\_\_\_\_

**Criteria****For Initial Authorization:**

1. Please indicate the diagnosis and information:

 **Moderate-to-Severe Atopic Dermatitis** **Other:** \_\_\_\_\_2. Is member inadequately controlled with topical prescription therapies? Yes  No 3. Is there a reason topical treatment is not advised? Yes  No 

a. If yes, please describe: \_\_\_\_\_

4. Has member failed 1 medium potency to very-high potency Tier-1 topical corticosteroid? Yes  No 

a. If yes, please provide the medication and duration of treatment:

i. Drug: \_\_\_\_\_ Date of trial: \_\_\_\_\_

ii. Was the trial at least 2 weeks in duration? Yes  No b. If no, is there a contraindication or documented intolerance to those medications? Yes  No 

i. If yes, please describe: \_\_\_\_\_

5. Has member failed 1 topical calcineurin inhibitor (e.g., pimecrolimus, tacrolimus)? Yes  No 

a. If yes, please provide the medication and duration of treatment:

i. Drug: \_\_\_\_\_ Date of trial: \_\_\_\_\_

ii. Was the trial at least 2 weeks in duration? Yes  No b. If no, is there a contraindication or documented intolerance to those medications? Yes  No 

i. If yes, please describe: \_\_\_\_\_

6. Member's weight: \_\_\_\_\_ kg

7. Member's body surface area (BSA) of atopic dermatitis involvement: \_\_\_\_\_

**(Page 1 of 2)**

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

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Member Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Member ID#: \_\_\_\_\_

**Criteria****For Initial Authorization: (continued)**

8. Is Ebglyss® prescribed by a dermatologist, allergist, or immunologist or has the member been evaluated by a dermatologist, allergist, or immunologist within the last 12 months (or an advanced care practitioner with a supervising physician who is a dermatologist, allergist, or immunologist)? Yes  No
9. Will Ebglyss® be used concurrently with other biologic medications? Yes  No
- a. If yes, please provide details and patient-specific information to support the concurrent use:

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Additional Information: \_\_\_\_\_

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**For Continued Authorization:**

1. Date of last dose: \_\_\_\_\_
2. Is the member responding well to treatment? Yes  No
3. Is the member compliant with therapy? Yes  No

Additional Information: \_\_\_\_\_

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**(Page 2 of 2)**

Prescriber Signature: \_\_\_\_\_ Date: \_\_\_\_\_

***I certify that the indicated treatment is medically necessary and all information is true and correct to the best of my knowledge. Failure to complete this form in full will result in processing delays.*****CONFIDENTIALITY NOTICE**

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