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:_____

Billing Provider 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. Is member inadequately controlled with topical prescription therapies? Yes ☐ No ☐
3. Is there a reason topical treatment is not advised? Yes ☐ No ☐
   i. If yes, please describe: _____
4. 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:_____
5. Has the member failed 1 topical calcineurin inhibitor [e.g., Elidel® (pimecrolimus), Protopic® (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:_____
6. 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:
   _____
7. 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 ☐

Compliance with all of the prior authorization criteria is a condition for payment for this drug by SoonerCare. All information must be provided and SoonerCare may verify through further requested documentation. The member's drug history will be reviewed prior to approval. *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:**_____

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.**