Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
Adbry (tralokinumab-ldrm) Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk
Length of Authorizations: Initial- 6 months; Continuation- 12 months

Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **Adbry (tralokinumab-ldrm).** Please complete all sections, incomplete forms will delay processing. Fax this form back to Kaiser Permanente within 24 hours (fax: 1-866-331-2104). If you have any questions or concerns, please call 1-866-331-2103. **Requests will not be considered unless all sections are complete.**

KP-MAS Formulary can be found at: Pharmacy | Community Provider Portal | Kaiser Permanente

1 – Patient Information

Patient Name: _____ Kaiser Medical ID#: _____ Date of Birth: _____

2 – Prescriber Information

Prescriber Name: _____ Specialty: _____ NPI: _____

Prescriber Address: _____

Prescriber Phone #: _____Prescriber Fax #: _____

3 – Pharmacy Information

Pharmacy Name: _____ Pharmacy NPI: _____

Pharmacy Phone #_____ Pharmacy Fax #: _____

4 – Drug Therapy Requested

Drug 1: Name/Strength/Formulation: _____

Sig: _____

Drug 2: Name/Strength/Formulation: _____

Sig: _____

5– Diagnosis/Clinical Criteria

1. Is this request for initial or continuing therapy?
   □ Initial therapy □ Continuing therapy, state start date: _____

2. Indicate the patient's diagnosis for the requested medication: _____

Clinical Criteria:

1. Prescriber is a Dermatologist or an Allergist,
   □ No □ Yes
2. **AND** patient is > 18 years of age,
   □ No □ Yes
3. **AND** documented diagnosis of moderate-to-severe atopic dermatitis (BSA > 10%),
   □ No □ Yes
4. **AND** documented inadequate response, intolerance or contraindication to BOTH of the following topical therapies for a minimum of 2 weeks each:
   a. Medium or very high potency topical corticosteroid
   b. Topical calcineurin inhibitors
   □ No □ Yes
5. **AND** documented treatment failure, contraindication or intolerance to narrow-band short wave ultraviolet B light (NB-UV light); history of worsening eczema with sunlight/heat is considered contraindication,
   □ No □ Yes
6. **AND** documented inadequate response (after at least 1 month of treatment), intolerance, or contraindication (i.e. pregnancy/breastfeeding, history of alcoholism or alcoholic liver disease, chronic liver disease, immunodeficiency syndrome, pre-existing blood dyscrasia, hemodialysis, or end-stage renal disease) to systemic immunomodulator (i.e., methotrexate, azathioprine, mycophenolate mofetil, or cyclosporine),
   □ No □ Yes
7. **AND** Adbry is NOT being used in combination with another biologic mediation (omalizumab, rituximab, etc.)
   □ No □ Yes

For continuation of therapy, please respond to additional questions below:

1. Documentation of positive clinical response to Adbry therapy,
   □ No □ Yes
2. **AND** specialist follow-up occurred since last review
   □ No □ Yes

6 – Prescriber Sign-Off

Additional Information –

1. **Please submit chart notes/medical records for the patient that are applicable to this request.**
2. **If member has not tried preferred agent(s) please provide rationale/explanation and any additional supporting information that should be taken into consideration for the requested medication:**

_____

_____

_____

I certify that the information provided is accurate. Supporting documentation is available for State audits.

Prescriber Signature:	**Date:**