Fax Completed Form To
1.833.404.2392
Prescriber Help Desk
1.833.587.2012
Online
covermymeds.com/main/prior-authorization-forms/

Request for Prior Authorization
Tralokinumab-ldrm (Adbry)
(PLEASE PRINT – ACCURACY IS IMPORTANT)

IA Medicaid Member ID #	Patient name	DOB
Patient address		
Provider NPI	Prescriber name	Phone
Prescriber address		Fax
Pharmacy name	Address	Phone
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.		
Pharmacy NPI	Pharmacy fax	NDC

Prior authorization (PA) is required for tralokinumab-ldrm (Adbry). Requests for non-preferred agents may be considered when documented evidence is provided that the use of preferred agent(s) would be medically contraindicated. Payment will be considered for an FDA approved or compendia indicated diagnosis for the requested drug when the following conditions are met:
1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warning and precautions, drug interactions, and use in specific populations; and
2. Patient has a diagnosis of moderate to severe atopic dermatitis; and
3. Is prescribed by or in consultation with a dermatologist; and
4. Patient has failed to respond to good skin care and regular use of emollients; and
5. Patient has documentation of an adequate trial and therapy failure with at least one preferred medium to high potency topical corticosteroid for a minimum of 2 consecutive weeks; and
6. Patient has documentation of a previous trial and therapy failure with a topical immunomodulator for a minimum of 4 weeks; and
7. Patient will continue with skin care regimen and regular use of emollients.
If criteria for coverage are met, initial authorization will be given for 16 weeks to assess the response to therapy. Request for continuation of therapy will require documentation of a positive response to therapy and documentation patient will continue with skin care regimen and regular use of emollients.
The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

Preferred

☐ Adbry

Strength	**Usage Instructions**	**Quantity**	**Day's Supply**
_____	_____	_____	_____

Diagnosis:_____

Prescriber Specialty: ☐ Dermatologist ☐ Other (specify): _____

If other, note consultation with dermatologist: Consultation date: _____

Physician name, specialty & phone: _____

Has patient failed to respond to good skin care and regular use of emollients? ☐ Yes ☐ No

Will patient continue with skin care regimen and regular use of emollients?
☐ Yes Emollient to be used:_____ ☐ No

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Preferred Medium to High Potency Topical Corticosteroid Trial:
Drug name & dose:_____ Trial dates:_____
Failure reason:_____

Preferred Topical Immunomodulator Trial:
Drug name & dose:_____ Trial dates:_____
Failure reason:_____

Requests for continuation therapy:

Does patient have a documented positive response to therapy?
☐ Yes (describe): _____
☐ No

Will patient continue with skin care regimen and regular use of emollients?
☐ Yes Emollient to be used:_____ ☐ No

Medical or contraindication reason to override trial requirements:_____

Attach lab results and other documentation as necessary.

Prescriber signature (Must match prescriber listed above.)	Date of submission

IMPORTANT NOTE: *In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Health and Human Services, that the member continues to be eligible for Medicaid.*