Trillium Health Resources
Pharmacy Prior Approval Request for

Monoclonal Antibodies: Adbry

Member Information

1. Last Name: _____ 2. First Name: _____
3. Trillium ID #: _____ 4. Date of Birth: _____ 5. Gender: _____

Prescriber Information

1. Prescriber Name: _____ 2. NPI #: _____
3. Requestor Name (Nurse/Office Staff): _____
4. Mailing Address: _____ City: _____ State: ____ Zip: _____
5. Phone #: _____ Ext. _____ Fax #: _____

Drug Information

1. Drug Name: **Adbry** 2. Strength: _____ 3. Quantity per 30 Days: _____
4. Length of Therapy: ☐ 30 Days ☐ 60 Days ☐ 90 Days ☐ 120 Days ☐ 180 Days ☐ 365 Days ☐ Other _____

Clinical Information

Initial Approval:

1. Is the member age 18 years of age or older? ☐ **Yes** ☐ **No**
2. Will the member receive live vaccines during Adbry therapy? ☐ **Yes** ☐ **No**
3. Does the member have a diagnosis of moderate to severe Atopic Dermatitis? ☐ **Yes** ☐ **No**
4. Does the member have at least 1 of the following? ☐ **Yes** ☐ **No Please indicate which one(s).** _____
   a. Involvement of at least 10% of body surface
   b. area (BSA); Eczema Area and Severity Index (EASI) score of 16 or greater
   c. Investigator's Global Assessment (IGA) score of 3 or more
   d. Scoring Atopic Dermatitis (SCORAD) score of 25 or more
   e. Incapacitation due to AD lesion location (i.e., head and neck, palms, soles, or genitalia)
5. Has the member had a trial and failure of at least 2 prescription topical steroids or have a documented adverse reaction or contraindication that precludes trial of at least 2 prescription topical steroids? ☐ **Yes** ☐ **No**
   Please list _____
6. Has the member had a trial and failure or documented adverse reaction or contraindication that precludes use of one of the following? ☐ **Yes** ☐ **No Please indicate which one(s).** _____
   a. Topical calcineurin inhibitor (e.g., pimecrolimus or tacrolimus)
   b. Topical phosphodiesterase-4 inhibitor (e.g., crisaborole)
   c. Topical Janus kinase inhibitor (e.g., ruxolitinib)
7. Will tralokinumab-ldrm (Adbry) be used in combination with other monoclonal antibody biologics (e.g., tezepelumab, omalizumab, mepolizumab, reslizumab, benralizumab, dupilumab)? ☐ **Yes** ☐ **No**

Initial approval can be for up to 16 weeks

For continuation of therapy, please answer questions 1-9

8. While on Adbry, has the member had disease improvement and/or stabilization from baseline supported by medical records? ☐ **Yes** ☐ **No**
9. Has the member experienced any serious treatment-related adverse events (e.g., serious infection, conjunctivitis, keratitis, eosinophilia)? ☐ **Yes** ☐ **No**

Reauthorizations can be for up to 6 months

** Please provide medical records documenting the member's current Atopic Dermatitis status and response to Adbry treatment**

Signature of Prescriber: _____ Date: _____

(Prescriber Signature Mandatory)

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to PerformRx at (833) 726-7628 or call Pharmacy PA Call Center: (855) 662-0277