Adbry (tralokinumab)
Prior Authorization Request Form

Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

MEMBER'S LAST NAME: _____ **MEMBER'S FIRST NAME:** _____

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

☐ **URGENT**

MEMBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PHONE NUMBER:	**DATE OF BIRTH:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
PATIENT INSURANCE ID NUMBER:	

☐ **MALE** ☐ **FEMALE** **HEIGHT (IN/CM):** _____ **WEIGHT (LB/KG):** _____ **ALLERGIES:** _____

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: HTTPS://MAGELLANRX.COM/MEMBER/EXTERNAL/COMMERCIAL/COMMON/DOC/EN-US/PHI_DISCLOSURE_AUTHORIZATION.PDF

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): _____
AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: _____

PRESCRIBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PRESCRIBER SPECIALTY:	**EMAIL ADDRESS:**
NPI NUMBER:	**DEA NUMBER:**
PHONE NUMBER:	**FAX NUMBER:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
REQUESTOR (if different than prescriber)**:**	**OFFICE CONTACT PERSON:**

MEDICATION OR MEDICAL DISPENSING INFORMATION			
MEDICATION NAME:			
DOSE/STRENGTH:	**FREQUENCY:**	**LENGTH OF THERAPY/REFILLS:**	**QUANTITY:**
☐ **NEW THERAPY** ☐ **RENEWAL** DURATION OF THERAPY (SPECIFIC DATES):		**IF RENEWAL:** DATE THERAPY INITIATED:	

Continued on next page.

Last Updated: 8/1/2022

Magellan Rx MANAGEMENT

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MEMBER'S LAST NAME: _____ **MEMBER'S FIRST NAME:** _____

1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? ☐ YES (if yes, complete below) ☐ NO		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE)**:**	**DURATION OF THERAPY** (SPECIFY DATES)**:**	**RESPONSE/REASON FOR FAILURE/ALLERGY:**

2. LIST DIAGNOSES:	**ICD-10:**
☐ Moderate to severe atopic dermatitis ☐ Other diagnosis: _____ICD-10_____	

3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.

Clinical Information:
Is the drug going to be used in conjunction with a clinical trial? ☐ Yes ☐ No
<u>Initial Request:</u>
Is the prescriber a dermatologist or an allergist? ☐ Yes ☐ No

Has the patient had the diagnosis of atopic dermatitis for at least 12 months? ☐ Yes ☐ No *Please submit documentation.*

Does the patient have atopic dermatitis on at least 10% or more of their body surface area? ☐ Yes ☐ No *Please submit documentation.*

Has the patient tried at least two different topical steroids? ☐ Yes ☐ No *Please submit documentation.*

If patient has not had at least 2 different topical steroids, has the patient tried at least one topical steroid AND one topical calcineurin inhibitor (tacrolimus or pimecrolimus)? ☐ Yes ☐ No *Please submit documentation.*

If patient has not had at least 2 different topical steroids, has the patient tried at least one topical steroid AND Eucrisa(crisaborole)? ☐ Yes ☐ No *Please submit documentation.*

Will Adbry(tralokinumab) be used in combination with Cibinqo(abrocitinib), Olumiant(baracitinib), RinvoqER(upadacitinib), Dupixent(dupilumab), or Opzelura(ruxolitinib)? ☐ Yes ☐ No

<u>Renewal Request</u>:
Is patient continuing to have a positive clinical response? ☐ Yes ☐ No *Please submit documentation.*

Is the prescriber a dermatologist or an allergist? ☐ Yes ☐ No

Will Adbry(tralokinumab) be used in combination with Cibinqo(abrocitinib), Olumiant(baracitinib), RinvoqER(upadacitinib), Dupixent(dupilumab), or Opzelura(ruxolitinib)? ☐ Yes ☐ No

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Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

***Please note:** Not all drugs/diagnoses are covered on all plans. This request may be denied unless all required information is received.

ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature or Electronic I.D. Verification: _____ **Date:** _____

FAX THIS FORM TO: 800-424-7640

MAIL REQUESTS TO: Magellan Rx Management Prior Authorization Program
Attn: CP – 4201
P.O. Box 64811
St. Paul, MN 55164-0811

Last Updated: 8/1/2022