

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.

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:		
DURATION OF THERAPY (SPE	RENEWAL CIFIC DATES):	IF RENEWAL: DATE THERAPY INITIATED:			

Continued on next page.

© 2017–2023 by Magellan Rx Management, LLC. All Rights Reserved. Last Updated: 8/1/2022



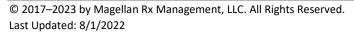






MEMBER'S LAST NAME: ______ MEMBER'S FIRST NAME: _____

1. HAS THE PATIENT TRIED ANY OTHER	R MEDICATIONS FOR THIS CONDITION?	YES (if yes, complete below) 📃 NO		
MEDICATION/THERAPY (SPECIFY	DURATION OF THERAPY (SPECIFY	RESPONSE/REASON FOR		
DRUG NAME AND DOSAGE):	DATES):	FAILURE/ALLERGY:		
2. LIST DIAGNOSES:		ICD-10:		
 Diagnoses: Moderate to severe atopic dermatitis 		ICD-10:		
Other diagnosis:ICD-10				
3. REQUIRED CLINICAL INFORMATION	PLEASE PROVIDE ALL RELEVANT CLINICA	AL INFORMATION TO SUPPORT A		
PRIOR AUTHORIZATION.				
Clinical Information:				
Is the drug going to be used in conjunc	tion with a clinical trial? Yes No			
Initial Request:				
Is the prescriber a dermatologist or an	allergist? 🗆 Yes 🗆 No			
Use the notions had the discussion of a	kan ia damaatitia fan at laast 12 maatha?			
documentation.	topic dermatitis for at least 12 months?	□ Yes □ No <i>"Please submit</i>		
documentation:				
Does the nationt have atonic dermatit	is on at least 10% or more of their body	surface area? □ Ves □ No * <i>Please</i>		
submit documentation.	is on at least 10% of more of their body			
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 differe	nt topical steroids, has the patient tried	l at least one topical steroid AND one		
topical calcineurin inhibitor (tacrolimus or pimecrolimus)?				
If patient has not had at least 2 differe	nt 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 Cibingo(abrocitinib), Olumiant(baracitinib),				
RinvoqER(upadacitinib), Dupixent(dupilumab), or Opzelura(ruxolitinib)? Yes Do				
Renewal Request:				
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)? Ves No				









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:

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:

CONFIDENTIALITY NOTICE: The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately (via return FAX) and arrange for the return or destruction of these documents.

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

