OKLAHOMA Health Care Authority

State of Oklahoma
SoonerCare
Adbry™ (Tralokinumab-ldrm) Prior Authorization Form

Member Name:____________________ Date of Birth:______________ Member ID#:________________

Drug Information

Pharmacy billing (NDC:________________________) Fill Date:________________________________

Dose:___________________________________ Regimen:___________________________________

Billing Provider Information

Pharmacy NPI:_________________________ Pharmacy Name:_________________________________

Pharmacy Phone:_______________________ Pharmacy Fax:__________________________________

Prescriber Information

Prescriber NPI:______________________ Prescriber Name:_____________________________________

Prescriber Phone:_________________ Prescriber Fax:_________________ Specialty:______________

Clinical Information

For Initial Authorization: (Initial approval will be for the duration of 16 weeks)

1. Diagnosis of moderate-to-severe atopic dermatitis? Yes ____ No ____
2. Is member inadequately controlled with topical prescription therapies? Yes____ No____
3. Is there a reason topical treatment is not advised? Yes____ No____
   i. If yes, please describe: ____
4. Has the member failed 1 medium potency to very-high potency Tier-1 topical corticosteroid? Yes____ No____
   i. If yes, please provide the medication and duration of treatment:
      a. Drug:____________________________________ Date of trial:____________________
      b. Was the trial at least 2 weeks in duration? Yes____ No____
   ii. If no, is there a contraindication or documented intolerance to medium potency to very-high potency Tier-1 topical corticosteroids? Yes____ No____
      a. If yes, please describe:____
5. Has the member failed 1 topical calcineurin inhibitor [e.g., Elidel® (pimecrolimus), Protopic® (tacrolimus)]? Yes____ No____
   i. If yes, please provide the medication and duration of treatment:
      a. Drug:____________________________________ Date of trial:____________________
      b. Was the trial at least 2 weeks in duration? Yes____ No____
   ii. If no, is there a contraindication or documented intolerance to topical calcineurin inhibitors? Yes____ No____
      a. If yes, please describe:____
6. Will the member be using Adbry™ concurrently with other biologic medications? Yes____ No____
   i. If yes, please provide patient-specific information to support the concurrent use of medications:
   ____
7. Has the member been evaluated by an allergist, dermatologist or immunologist within the last 12 months (or an advanced care practitioner with a supervising physician who is one of these specialties)? Yes___ No___
   i. If yes, please include name of specialist: ________________________ Specialty:______________

For Continued Authorization:

1. Is member compliant with therapy? Yes___ No___
2. Is member responding well to therapy? Yes____ No____

Compliance with all of the prior authorization criteria is a condition for payment for this drug by SoonerCare. All information must be provided and SoonerCare may verify through further requested documentation. The member's drug history will be reviewed prior to approval. *Please do not send in chart notes. Specific information/ documentation will be requested if necessary.* Please complete and return <u>all</u> pages. *Failure to complete all pages will result in processing delays.*

Prescriber Signature:__________________________________ Date:______________________

PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:	CONFIDENTIALITY NOTICE
University of Oklahoma College of Pharmacy Pharmacy Management Consultants Product Based Prior Authorization Unit Fax: 1-800-224-4014 Phone: 1-800-522-0114 Option 4	*This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.*