OKLAHOMA Health Care Authority

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State of Oklahoma SoonerCare

Ebglyss™ (lebrikizumab-lbkz) Prior Authorization Form

Member Name: _____ ***Date of Birth:*** _____ ***Member ID#:*** _____

Drug Information

Pharmacy Billing (NDC: _____***) Start Date (or date of next dose):*** _____

Dose: _____ ***Regimen:*** _____

Pharmacy Information

Pharmacy NPI: _____ ***Pharmacy Name:*** _____

Pharmacy Phone: _____ ***Pharmacy Fax:*** _____

Prescriber Information

Prescriber NPI: _____ ***Prescriber Name:*** _____

Prescriber Phone: _____ ***Prescriber Fax:*** _____ ***Specialty:*** _____

Criteria

For Initial Authorization:

1. Please indicate the diagnosis and information:
   - ☐ **Moderate-to-Severe Atopic Dermatitis**
   - ☐ **Other:** _____
2. Is member inadequately controlled with topical prescription therapies? Yes☐ No☐
3. Has member failed 1 medium potency to very-high potency Tier-1 topical corticosteroid? Yes☐ No☐
   a. If yes, please provide the medication and duration of treatment:
      i. Drug: _____ Date of trial: _____
      ii. Was the trial at least 2 weeks in duration? Yes☐ No☐
   b. If no, is there a contraindication or documented intolerance to those medications? Yes☐ No☐
      i. If yes, please describe: _____
4. Has member failed 1 topical calcineurin inhibitor (e.g., pimecrolimus, tacrolimus)? Yes☐ No☐
   a. If yes, please provide the medication and duration of treatment:
      i. Drug: _____ Date of trial: _____
      ii. Was the trial at least 2 weeks in duration? Yes☐ No☐
   b. If no, is there a contraindication or documented intolerance to those medications? Yes☐ No☐
      i. If yes, please describe: _____
5. Member's weight: _____kg
6. Member's current body surface area (BSA) of atopic dermatitis involvement: _____
7. Please provide a patient-specific, clinically significant reason why the member cannot use Adbry® (tralokinumab-ldrm) and Dupixent® (dupilumab): _____
   _____

Fax completed prior authorization request form to 888-601-8461 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts. All requested data must be provided. Incomplete forms or forms without the chart notes will be returned. Pharmacy Coverage Guidelines are available at AetnaBetterHealth.com/Oklahoma.

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Criteria

For Initial Authorization: ***(continued)***

8. Is Ebglyss® prescribed by a dermatologist, allergist, or immunologist or has the member been evaluated by a dermatologist, allergist, or immunologist within the last 12 months (or an advanced care practitioner with a supervising physician who is a dermatologist, allergist, or immunologist? Yes☐ No☐
9. Will Ebglyss® be used concurrently with other biologic medications? Yes☐ No☐
    a. If yes, please provide details and patient-specific information to support the concurrent use:

_____

_____

Additional Information: _____

_____

_____

For Continued Authorization:

1. Date of last dose: _____
2. Is the member responding well to treatment? Yes☐ No☐

Additional Information: _____

_____

Prescriber Signature: _____ **Date:** _____

I certify that the indicated treatment is medically necessary and all information is true and correct to the best of my knowledge. *Failure to complete this form in full will result in processing delays.*

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