maryland physicians care
Medicaid with a Heart

PRIOR AUTHORIZATION REQUEST

Ebglyss

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll-free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please note that supporting clinical documentation is required for **ALL** PA requests. Pharmacy prior authorization reviews can be subject to trial with additional medications that are not listed within the criteria. The policies are subject to change based on COMAR requirements, MDH transmittals and updates to treatment guidelines.

1	Is the request an INITIAL or CONTINUATION of therapy? [] Initial (If checked, go to 7) [] Continuation (If checked, go to 2)		
2	Is the patient currently receiving the requested medication? [If no, skip to question 7.]	Yes	No

If you have any questions, call: 1-888-258-8250

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3	Has the patient been receiving medication samples of Ebglyss? [If yes, skip to question 7.]	Yes	No
4	Does the patient have a previously approved prior authorization (PA) on file with the current plan? [Note: If the patient does NOT have a previously approved PA on file for the requested medication with the current plan, the renewal request will be considered under initial therapy.] [If no, skip to question 7.]	Yes	No
5	Will the patient be concurrently receiving the requested medication in combination with any monoclonal antibody, anti-IL4, anti-IL5, or TSLP inhibitor such as Adbry, Cinqair, Dupixent, Fasenra, Nemluvio, Nucala, Tezspire or Xolair? [If yes, no further questions.]	Yes	No
6	Has the patient been taking the requested medication for at least 4 months and has experienced a clinically significant benefit from the medication, as documented by the prescriber? ACTION REQUIRED: Submit supporting documentation. [Note: Atopic dermatitis – Examples of a response to the requested medication are marked improvements in erythema, induration/papulation/edema, excoriations, and lichenification; reduced pruritus; decreased requirement for other topical or systemic therapies; reduced body surface area affected with atopic dermatitis; or other responses observed] [No further questions.]	Yes	No
7	What is the indication or diagnosis? [] Atopic dermatitis (If checked, go to 8) [] Other (If checked, no further questions)		
8	Is the patient greater than or equal to 12 years of age?	Yes	No
9	What is the weight of the patient? [] Less than 40 kg (If checked, no further questions) [] More than or equal to 40 kg (If checked, go to 10)		
10	Will the patient be concurrently receiving the requested medication in combination with	Yes	No

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	any monoclonal antibody, anti-IL4, anti-IL5, or TSLP inhibitor such Adbry, Cinqair, Dupixent, Fasenra, Nemluvio, Nucala, Tezspire or Xolair? [If yes, no further questions.]		
11	Has the patient undergone treatment with any immunosuppressive medications within the last 4 weeks (e.g., systemic corticosteroids, cyclosporine, mycophenolate-mofetil, IFN-γ, Janus kinase inhibitors, azathioprine, methotrexate, etc.)? [If yes, no further questions.]	Yes	No
12	Does the patient have a documented diagnosis of moderate to serve atopic dermatitis? [If no, no further questions.]	Yes	No
13	Does the prescribed dosing exceed FDA approved indication? [If yes, no further questions.]	Yes	No
14	Has documentation been provided to confirm that the patient has an IGA score of greater than or equal to 3 and an EASI score of greater than or equal to 16? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
15	Does the patient have atopic dermatitis involvement estimated to be greater than or equal to 10% of the body surface area (BSA) according to the prescriber? ACTION REQUIRED: Submit supporting documentation. [If yes, go to question 17.]	Yes	No
16	Does the patient have atopic dermatitis affecting the following areas: hands, face, feet, eyes/eyelids, neck, scalp, skin folds, and/or genitalia? [If no, no further questions.]	Yes	No
17	Has the patient tried at least TWO medium-, medium-high, high-, and/or super-high-potency prescription topical corticosteroids? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
18	Has the patient tried tacrolimus ointment? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
19	Were the topical corticosteroids and tacrolimus ointment applied daily for at least 28 consecutive days? [If no, no further questions.]	Yes	No

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20	Was inadequate efficacy demonstrated with the topical therapies, according to the prescriber? [If no, no further questions.]	Yes	No
21	Has the patient tried Zoryve? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
22	Was Zoryve applied daily for at least 56 consecutive days? [If no, no further questions.]	Yes	No
23	Was inadequate efficacy demonstrated with Zoryve, according to the prescriber? [If no, no further questions.]	Yes	No
24	Is the requested medication being prescribed by or in consultation with an allergist, immunologist, or dermatologist?	Yes	No

Please document the diagnoses, symptoms, and/or any other information important to this review:

SECTION B: Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 1-833-896-0656

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

Confidentiality: The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.

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