



## PRIOR AUTHORIZATION REQUEST

### ADBRY

**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	Will the patient be using the requested medication in combination with another monoclonal antibody (for example, Dupixent, Cinqair, Fasenna, Nucala, Tezspire, Xolair)? [If yes, no further questions.]	Yes	No
2	Is the request an INITIAL or CONTINUATION of therapy?  [] Initial (If checked, go to 8)		

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

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Continuation (If checked, go to 3)

3	Is the patient currently receiving the requested medication? [If no, skip to question 8.]	Yes	No
4	Has the patient been receiving medication samples for Adbry? [If yes, skip to question 8.]	Yes	No
5	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 8.]	Yes	No
6	Has the patient been established on therapy for at least 3 months? [If no, skip to question 8.]	Yes	No
7	Has documentation been submitted to confirm that the patient has had a clinically significant response, as determined by the provider? ACTION REQUIRED: Submit supporting documentation. [No further questions.]	Yes	No
8	What is the indication or diagnosis?  <input type="checkbox"/> Atopic dermatitis (If checked, go to 9)  <input type="checkbox"/> Asthma (If checked, no further questions)  <input type="checkbox"/> Idiopathic Pulmonary Fibrosis (If checked, no further questions)  <input type="checkbox"/> Ulcerative Colitis (If checked, no further questions)  <input type="checkbox"/> Other (If checked, no further questions)		
9	Is the patient greater than or equal to 12 years of age? [If no, no further questions.]	Yes	No
10	Does the patient have a documented diagnosis of moderate to severe atopic dermatitis? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
11	Does the patient have atopic dermatitis involvement estimated to be greater than or equal to 10% of the body surface area according to the prescriber? [If no, no further questions.]	Yes	No
12	Has the patient had trial and failure, contraindication or intolerance to ALL the	Yes	No

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following therapeutic classes applied for at least 28 consecutive days: A) TWO medium, medium-high, high-, and/or super-high potency prescription topical corticosteroids (for example, fluocinonide, mometasone furoate), B) Topical calcineurin inhibitors (for example, tacrolimus), AND C) Topical phosphodiesterase (PDE) inhibitors (for example, Eucrisa)?  
[If no, no further questions.]

- |    |                                                                                                                                                                                                                                                                                                                             |     |    |
|----|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|----|
| 13 | Prior to initiation, has the patient completed all age-appropriate vaccinations as recommended by current immunization guidelines?<br>[If no, no further questions.]                                                                                                                                                        | Yes | No |
| 14 | Is the requested medication being prescribed by or in consultation with an allergist, immunologist, or dermatologist?<br>[If no, no further questions.]                                                                                                                                                                     | Yes | No |
| 15 | Does the prescribed dosing exceed FDA approved indication?<br>[Note: Dosing for patients 12-17 years of age: 300 mg loading dose (LD) and 150 mg subcutaneous every other week maintenance dose (MD). Dosing for patients greater than or equal to 18 years of age: 600 mg LD and 300 mg subcutaneous every other week MD.] | 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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