Prior Authorization Criteria

MISSISSIPPI DIVISION OF MEDICAID

Adbry (tralokinumab) PA Criteria FOR ATOPIC DERMATITIS:

- Adbry (tralokinumab) is an interleukin-13 antagonist indicated for the treatment of moderate to severe atopic dermatitis in adult patients whose disease is not adequately controlled with topical prescription therapies or when those therapies are not advisable.
- *Adbry can be used with or without topical corticosteroids.*

ICD-10 code(s):_____

Submission of medical records or prescription claims history documenting the following requirements for the indications below is **required upon request**.

Adbry FOR ATOPIC DERMATITIS may be approved based on **ALL** of the following criteria:

INITIAL AUTHORIZATION: (will be issued for 6 months)

☐ Yes ☐ No Diagnosis of moderate to severe chronic atopic dermatitis;

-AND-

☐ Yes ☐ No Age of patient is within the age range as recommended by the FDA label;

-AND-

☐ Yes ☐ No Prescribed by or in consultation with an allergist, dermatologist or immunologist;

-AND-

☐ Yes ☐ No Patient is **not** receiving Adbry in combination with another biologic medication for the treatment of atopic dermatitis [e.g., Enbrel (etanercept), Remicade/Inflectra (infliximab), Xolair (omalizumab), Rituxan (rituximab), Dupixent (dupilumab)];

-AND-

☐ Yes ☐ No Patient has a documented failure, intolerance, or contraindication to ONE of the three following scenarios:

☐ Yes ☐ No 1. **For moderate atopic dermatitis: BOTH of the following:**

- One preferred medium to very-high potency topical corticosteroid ≥ 2 week trial (1 claim in last 365 days);

-and-

- **Either** one topical calcineurin inhibitor [Elidel/pimecrolimus or Protopic/tacrolimus] **-or-** Eucrisa (crisaborole) used for ≥ 4 week trial (1 claim in the last 90 days);

-OR-

☐ Yes ☐ No 2. **For severe atopic dermatitis: BOTH of the following:**

- One preferred medium to very-high potency topical corticosteroid ≥ 2 week trial (1 claim in the last 365 days);

-and-

- One topical calcineurin inhibitor [Elidel /pimecrolimus or Protopic/tacrolimus] used for ≥ 4 week trial (1 claim in the last 90 days);

-OR-

☐ Yes ☐ No 3. Patient is currently on Adbry therapy;

-AND-

☐ Yes ☐ No Prescribed dose does not exceed the following:

- Initial (one-time) dose: 600 mg
- Maintenance dose: 300 mg every other week

<u>REAUTHORIZATION</u>: (will be issued for 12 months)

☐ Yes ☐ No Patient continues to meet initial authorization criteria;

-AND-

☐ Yes ☐ No Prescribed dose does not exceed the following;

- Maintenance dose: 300 mg every other week or monthly;

-AND-

☐ Yes ☐ No Positive clinical response to Adbry therapy (e.g., reduction in body surface area, reduction in pruritus severity).