

TRICARE Prior Authorization Request Form for
tralokinumab-LDRM (**Adbry, Adbry Autoinjector**)



JOHNS HOPKINS
HEALTH PLANS

7231 Parkway Drive, Suite 100, Hanover, MD 21076

**FAX Completed Form and
Applicable Progress Notes to:
(410) 424-4037**

USFHP Pharmacy Prior Authorization Form

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Initial approvals expire after twelve months, renewal approvals are indefinite. For renewal of therapy an initial Tricare prior authorization approval is required.

Step 1 Please complete patient and physician information (please print):

1 Patient Name:	_____	Physician Name:	_____
Address:	_____	Address:	_____
	_____		_____
Sponsor ID #:	_____	Phone #:	_____
Date of Birth	_____	Secure Fax #:	_____

Step 2 Please complete the clinical assessment:

1. Has the patient received this medication under the TRICARE benefit in the last 6 months? Please choose "No" if the patient did not previously have a TRICARE approved PA for Adbry.	<input type="checkbox"/> Yes (subject to verification) Proceed to question 2	<input type="checkbox"/> No Proceed to question 3
2. Has the patient's disease severity improved and stabilized to warrant continued therapy?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No STOP Coverage not approved
3. For which indication is the requested medication being prescribed?	<input type="checkbox"/> Moderate to severe or uncontrolled atopic dermatitis - Proceed to question 4 <input type="checkbox"/> Other - STOP Coverage not approved	
4. Is the patient 12 years of age or older?	<input type="checkbox"/> Yes Proceed to question 5	<input type="checkbox"/> No STOP Coverage not approved
5. Is the requested medication being prescribed by a dermatologist, allergist, or immunologist?	<input type="checkbox"/> Yes Proceed to question 6	<input type="checkbox"/> No STOP Coverage not approved

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<p>6. Does the patient have a contraindication to, intolerability to, or have they failed treatment with ONE medication in EACH of the following two categories:</p> <ul style="list-style-type: none"> • topical corticosteroids – <ul style="list-style-type: none"> ○ for patients 18 years of age or older: high potency/class 1 topical corticosteroids (such as, clobetasol propionate 0.05% ointment/cream, fluocinonide 0.05% ointment/cream) OR ○ for patients 12 to 17 year of age: any topical corticosteroid AND • topical calcineurin inhibitor (for example, tacrolimus, pimecrolimus)? 	<input type="checkbox"/> Yes Proceed to question 7	<input type="checkbox"/> No STOP Coverage not approved
<p>7. Does the patient have a contraindication to, intolerability to, inability to access treatment, or have they failed treatment with Narrowband ultraviolet B (UVB) phototherapy?</p>	<input type="checkbox"/> Yes Proceed to question 8	<input type="checkbox"/> No STOP Coverage not approved
<p>8. Is the patient taking any other immunobiologics (for example, benralizumab [Fasenra], mepolizumab [Nucala], or omalizumab [Xolair])</p>	<input type="checkbox"/> Yes STOP Coverage not approved	<input type="checkbox"/> No Sign and date below

Step 3 I certify the above is true to the best of my knowledge. Please sign and date:

_____ Prescriber Signature

_____ Date

[10 July 2024]

For Internal Use Only	
<input type="checkbox"/> Approved:	Duration of Approval: ____month(s)
<input type="checkbox"/> Denied:	Authorized By:
<input type="checkbox"/> Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: