Member Name: ______________________________ Member ID: ________________ Member DOB: ________________

Drug Name: _____________________________ Strength: _______________ Directions: ______________________________________

Physician Name: __________________________ Physician Phone #: _________________________ Specialty: _____________________

Physician Fax #: _____________________ Pharmacy Name: ____________________________Pharmacy Phone: __________________

Horizon NJ Health

Tralokinumab-ldrm (Adbry) – Medical Necessity Request

*****Complete page 1 for Initial Requests Only*****

General Questions:

1. What is the prescriber's specialty managing the medication?

□ Allergy □ Dermatology □ Other: ____________________

Diagnosis:

□ Atopic Dermatitis (Eczema)

a) Please indicate the severity of atopic dermatitis: □ mild □ moderate □ severe

b) Is at least 10% of the member's body surface area affected? **Yes or No**

c) Does the member have clinically difficult to treat areas (e.g., face, neck, genital) that interfere with quality of life? **Yes** or **No**

a. If **Yes:** What are the affected areas?

____

d) Has the member tried and failed topical corticosteroid therapy for the diagnosis provided?

□ **Yes**: Please provide what topical therapies (name, strength, and dosage form) the member has failed.

____

□ **No**: Can the member try a medium to very high potency topical corticosteroid (e.g. mometasone ointment 0.1%, betamethasone dipropionate ointment 0.05%, etc) instead?

□ **Yes**: Please notify the pharmacy of the change and return the form.

□ **No**: Please provide the clinical reason why a topical corticosteroid cannot be tried.

____

e) Has the member tried and failed systemic immunosuppressive therapy [e.g., cyclosporine, methotrexate, azathioprine] medically appropriate for Atopic Dermatitis?

□ **Yes**: Please provide what systemic immunosuppressive therapy (name) the member has failed.

____

□ **No**: Can the member try systemic immunosuppressive therapy [e.g., methotrexate, azathioprine] instead?

□ **Yes**: Please notify the pharmacy of the change and return the form.

Physician office's signature*________________________________ Print Name________________________________

***Form must be completed and signed by physician or licensed representative from the physician's office**

□ **No:** Please provide the clinical reason why a systemic immunosuppressive therapy cannot be tried.
____

f) Has the member tried and failed a topical calcineurin inhibitor [tacrolimus (Protopic), pimecrolimus (Elidel)]?
□ **Yes**: Please provide what calcineurin inhibitor (name) the member has failed.
____
□ **No**: Can the member try a calcineurin inhibitor [tacrolimus (Protopic), pimecrolimus (Elidel)] instead?
□ **Yes**: Please notify the pharmacy of the change and return the form.
□ **No**: Please provide the clinical reason why a calcineurin inhibitor cannot be tried.
____

g) Has the member tried and failed any other therapies (pharmacological and/or non-pharmacological) for the diagnosis provided?
□ **Yes**: Please provide what other therapies the member has failed. _________________________________

____

□ **No**

h) Will the member be using any other biologic drug [e.g., Dupixent, Rinvoq, Cibinqo, etc.] or Opzelura cream with Adbry?
□ Yes: Please provide the drug name and diagnosis it is being used to treat.
____
□ **No**

i) Will the member continue to use topical emollients together with Adbry in problem areas (e.g., face, neck, genitals) to help prevent flares? **Yes or No**
j) Will the success of treatment be assessed regularly? **Yes or No**

□ **Other Diagnosis**: ____

Physician office's signature*_________________________________ Print Name________________________________
***Form must be completed and signed by physician or licensed representative from the physician's office**

Member Name: ______________________________ Member ID: ________________ Member DOB: ________________

Drug Name: ______________________________ Strength: _______________ Directions: ____

Physician Name: ___________________________ Physician Phone #: _________________________ Specialty: ______________________

Physician Fax #: _____________________ Pharmacy Name: ____________________________Pharmacy Phone: __________________

Horizon NJ Health

– Medical Necessity Request

*****Complete page 2 only for Subsequent/Renewal requests*****

□ **Atopic Dermatitis (Eczema)**

1. Has the member responded to treatment as demonstrated by an improvement and/or stabilization (eg, results) compared to baseline? **Yes or No**

2. Will the member continue the use of emollients together with Adbry in problem areas (e.g., face, neck, genitals) to prevent flares? **Yes or No**

3. Will the member be using any other biologic drug [e.g., Dupixent, Rinvoq, Cibinqo,, etc.] or Opzelura cream with Adbry?
   □ **Yes**: Please provide the drug name and diagnosis it is being used to treat.

____

   □ **No**

□ **Other Diagnosis**: ____

Physician office's signature*_________________________________ **Print Name**________________________________

***Form must be completed and signed by physician or licensed representative from the physician's office**