SENTARA HEALTH PLANS

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: Ebglyss™ (lebrikizumab-lbkz)

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight (if applicable): _____ **Date weight obtained:** _____

Recommended Dosage:

- 500 mg (two 250 mg injections) at Week 0 and Week 2, followed by 250 mg every other week until Week 16 or later; once clinical response is achieved, reduce to maintenance dose of 250 mg every 4 weeks. **NOTE: After 16 weeks of treatment, for patients who achieve clear or almost clear skin, the maintenance dosage is 250 mg every four weeks**

Quantity Limits: 1 pen/syringe per 28 days

NOTE: The Health Plan considers the use of concomitant therapy with another biologic immunomodulator (e.g., Adbry, Dupixent, Nucala, Xolair, Cibinqo, Rinvoq, Opzelura) prescribed for the same or different indications to be experimental and investigational. Safety and efficacy of these combinations have **NOT** been established and will **NOT** be permitted.

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- Will the member be discontinuing a previously prescribed biologic product if approved for requested medication? ❑ Yes **OR** ❑ No
- If yes, please list the medication that will be discontinued and the medication that will be initiated upon approval along with the corresponding effective date.

Medication to be discontinued: _____ **Effective date:** _____

Medication to be initiated: _____ **Effective date:** _____

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

Diagnosis: Moderate-to-Severe Atopic Dermatitis

Initial Authorization: 4 months

- ❑ Prescribed by or in consultation with an allergist, dermatologist or immunologist
- ❑ Member is 12 years of age or older and weighs 40 kg or greater
- ❑ Member has a diagnosis of **moderate to severe atopic dermatitis** with disease activity confirmed by **ONE** of the following:
  - ❑ Body Surface Area (BSA) involvement ≥ 10%
  - ❑ Eczema Area and Severity Index (EASI) score ≥ 16
  - ❑ Investigator's Global Assessment (IGA) score ≥ 3
  - ❑ Scoring Atopic Dermatitis (SCORAD) score ≥ 25
- ❑ Member has tried and failed at least **TWO** of the following therapies **(check all that apply; verified by chart notes and/or pharmacy paid claims)**:
  - ❑ 30 days (14 days for very high potency) of therapy with **ONE** medium to very-high potency topical corticosteroid in the past 180 days
  - ❑ 30 days of therapy with **ONE** topical calcineurin inhibitor in the past 180 days (e.g., tacrolimus ointment, pimecrolimus cream*) (*requires prior authorization)
  - ❑ 30 days of therapy with **ONE** topical phosphodiesterase-4 enzyme inhibitor in the past 180 days (e.g., Eucrisa*, Zoryve 0.15% cream*) (*requires prior authorization)
  - ❑ 30 days of therapy with **ONE** topical janus kinase inhibitor in the past 180 days (e.g., Opzelura*) (*requires prior authorization)
  - ❑ 90 days of therapy with **ONE** generic oral DMARD (e.g., azathioprine, cyclosporine, methotrexate, mycophenolate mofetil)
- ❑ Member has tried and failed **BOTH** of the following **(verified by chart notes/and or pharmacy paid claims)**:
  - ❑ Dupixent® (dupilumab) *requires prior authorization*
  - ❑ Rinvoq® (Upadacitinib) *requires prior authorization*

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Reauthorization: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

- ❑ Member has experienced a positive clinical response to Ebglyss™ therapy (e.g., reduced BSA involvement, decrease in severity based on physician assessment) (**chart notes must be submitted**)
- ❑ Provider submits clinical documentation to support **ONE** of the following:
  - ❑ **For 12-month reauthorization –** Maintenance dosage has been decreased to 250 mg every 4 weeks
  - ❑ **For 4-month reauthorization** – Member must meet **BOTH** of the following:
    - ❑ Member has been compliant on Ebglyss™ 250 mg every other week for 16 weeks and has **NOT** achieved clinical response (e.g., IGA 0 or 1, EASI-75, BSA <10%) (**verified by pharmacy paid claims; chart notes must be submitted**)
    - ❑ Provider attests once clinical response is achieved on Ebglyss™ 250 mg every other week dose, maintenance dose will be reduced to 250 mg every 4 weeks

Medication being provided by Specialty Pharmacy – Proprium Rx

Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.*

***Approved by Pharmacy and Therapeutics Committee**: **11/21/2024**
REVISED/UPDATED/REFORMATTED: ~~12/4/2024,~~ **4/09/2026**