# SENTARA COMMUNITY PLAN
# (MEDICAID)

## 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 two weeks until Week 16 or later once clinical response is achieved. **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) to be experimental and investigational. Safety and efficacy of these combinations have NOT been established and will NOT be permitted.**

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**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.

**Initial Authorization: 12 months**

- ❑ Member has a diagnosis of moderate to severe atopic dermatitis
- ❑ Member is 12 years of age or older
- ❑ Prior documented trial and failure of 8 weeks of each of the following:
  - ❑ One (1) topical corticosteroid of medium to high potency (e.g., mometasone, triamcinolone)
  - ❑ One (1) topical calcineurin inhibitor (tacrolimus or pimecrolimus)
  - ❑ Trial and failure of Dupixent®

**Medication being provided by Specialty Pharmacy - PropriumRx**

***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.***