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 and weighs 40 kg or greater
- ❑ Prior documented trial and failure of 30 days for **ONE** 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®
- ❑ Trial and failure of Adbry®

Reauthorization: 12 months. Check below all that apply. All criteria must be checked for approval. To support each line checked, all documentation (lab results, diagnostics, and/or chart notes) must be provided or request may be denied.

- ❑ Member has experienced therapeutic benefit from the requested medication
- ❑ Member is free of toxicity from the requested medication

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.*