# State of Oklahoma
## SoonerCare
## Ebglyss™ (lebrikizumab-lbkz) Prior Authorization Form

***Member Name:_______________________ Date of Birth:_____________ Member ID#:_________________***

## Drug Information

***Pharmacy Billing (NDC:____________________) Start Date (or date of next dose):__________________***

***Dose:__________________________________ Regimen:_______________________________________***

## Pharmacy Information

***Pharmacy NPI:____________________________ Pharmacy Name:________________________________***

***Pharmacy Phone:_________________________ Pharmacy Fax:__________________________________***

## Prescriber Information

***Prescriber NPI:____________________ Prescriber Name:________________________________________***

***Prescriber Phone:_______________ Prescriber Fax:__________________ Specialty:________________***

## Criteria

**For Initial Authorization:**

1. Please indicate the diagnosis and information:
   - ❑ **Moderate-to-Severe Atopic Dermatitis**
   - ❑ **Other: _____________________________**
2. Is member inadequately controlled with topical prescription therapies? Yes___ No___
3. Has member failed 1 medium potency to very-high potency Tier-1 topical corticosteroid? Yes___ No___
   a. If yes, please provide the medication and duration of treatment:
      i. Drug: ___________________________ Date of trial: ____________________________
      ii. Was the trial at least 2 weeks in duration? Yes___ No___
   b. If no, is there a contraindication or documented intolerance to those medications? Yes___ No___
      i. If yes, please describe: ____________________________________________________
4. Has member failed 1 topical calcineurin inhibitor (e.g., pimecrolimus, tacrolimus)? Yes___ No___
   a. If yes, please provide the medication and duration of treatment:
      i. Drug: ___________________________ Date of trial: ____________________________
      ii. Was the trial at least 2 weeks in duration? Yes___ No___
   b. If no, is there a contraindication or documented intolerance to those medications? Yes___ No___
      i. If yes, please describe: ____________________________________________________
5. Member's weight: ______kg
6. Member's current body surface area (BSA) of atopic dermatitis involvement: ____________
7. Please provide a patient-specific, clinically significant reason why the member cannot use Adbry® (tralokinumab-ldrm) and Dupixent® (dupilumab): ____________________________________________
   _____________________________________________________________________________________



PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:

University of Oklahoma College of Pharmacy
Pharmacy Management Consultants
Product Based Prior Authorization Unit

Fax: 1-800-224-4014
Phone: 1-800-522-0114 Option 4

CONFIDENTIALITY NOTICE

*This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.*



DRAFT

# State of Oklahoma
## SoonerCare
## Ebglyss™ (lebrikizumab-lbkz) Prior Authorization Form

***Member Name:_______________________ Date of Birth:_____________ Member ID#:_________________***

**Criteria**

**For Initial Authorization:** ***(continued)***

8. Is Ebglyss® prescribed by a dermatologist, allergist, or immunologist or has the member been evaluated by a dermatologist, allergist, or immunologist within the last 12 months (or an advanced care practitioner with a supervising physician who is a dermatologist, allergist, or immunologist? Yes___ No___
9. Will Ebglyss® be used concurrently with other biologic medications? Yes___ No___
   a. If yes, please provide details and patient-specific information to support the concurrent use:
   ______________________________________________________________________
   ______________________________________________________________________

Additional Information: ___________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

**For Continued Authorization:**

1. Date of last dose:______________________________
2. Is the member responding well to treatment? Yes____ No____

Additional Information:____________________________________________________________
______________________________________________________________________________

DRAFT



**Prescriber Signature:_________________________________ Date:_______________________**
***I certify that the indicated treatment is medically necessary and all information is true and correct to the best of my knowledge.*** *Failure to complete this form in full will result in processing delays.*

| PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO: | CONFIDENTIALITY NOTICE |
| --- | --- |
| University of Oklahoma College of Pharmacy<br>Pharmacy Management Consultants<br>Product Based Prior Authorization Unit<br><br>Fax: 1-800-224-4014<br>Phone: 1-800-522-0114 Option 4 | *This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.* |