

USFHP Prior Authorization Request Form for
tralokinumab-LDRM (**Adbry, Adbry Autoinjector**)

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be faxed to 855-273-5735

OR

The patient may attach the completed form to the prescription and **mail** it to:

Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? Call 1-877-880-7007

<https://www.usfamilyhealth.org/for-providers/pharmacy-information/>

Initial approvals expire after twelve months, renewal approvals are indefinite. For renewal of therapy an initial Tricare prior authorization approval is required. Clinical documentation may be required.

Step 1 Please complete patient and physician information (please print):

Patient Name: _____	Physician Name: _____
Address: _____	Address: _____
Sponsor ID #: _____	Phone #: _____
Date of Birth: _____	Secure Fax #: _____

Step 2 Please complete the clinical assessment:

1. Has the patient received this medication under the TRICARE benefit in the last 6 months? Please choose "No" if the patient did not previously have a TRICARE approved PA for Adbry.	☐ Yes (subject to verification) Proceed to question 2	☐ No Proceed to question 3
2. Has the patient's disease severity improved and stabilized to warrant continued therapy?	☐ Yes Sign and date below	☐ No STOP Coverage not approved
3. For which indication is the requested medication being prescribed?	☐ Moderate to severe or uncontrolled atopic dermatitis - Proceed to question 4 ☐ Other - STOP Coverage not approved	
4. Is the patient 12 years of age or older?	☐ Yes Proceed to question 5	☐ No STOP Coverage not approved
5. Is the requested medication being prescribed by a dermatologist, allergist, or immunologist?	☐ Yes Proceed to question 6	☐ No STOP Coverage not approved

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6. Does the patient have a contraindication to, intolerability to, or have they failed treatment with ONE medication in EACH of the following two categories: • topical corticosteroids – ○ for patients 18 years of age or older: high potency/class 1 topical corticosteroids (such as, clobetasol propionate 0.05% ointment/cream, fluocinonide 0.05% ointment/cream) OR ○ for patients 12 to 17 year of age: any topical corticosteroid AND • topical calcineurin inhibitor (for example, tacrolimus, pimecrolimus)?	☐ Yes Proceed to question 7	☐ No STOP Coverage not approved
7. Does the patient have a contraindication to, intolerability to, inability to access treatment, or have they failed treatment with Narrowband ultraviolet B (UVB) phototherapy?	☐ Yes Proceed to question 8	☐ No STOP Coverage not approved
8. Is the patient taking any other immunobiologics (for example, benralizumab [Fasenra], mepolizumab [Nucala], or omalizumab [Xolair])	☐ Yes STOP Coverage not approved	☐ No Sign and date below

Step 3 I certify the above is true to the best of my knowledge. Please sign and date:

Prescriber Signature

Date

[10 July 2024]