US Family Health Plan

Prior Authorization Request Form for

Lebrikizumab (Ebglyss)

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**

PA expires in 1 year. Renewal PA criteria will be approved indefinitely. Non-FDA-approved uses are not approved.

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:**

Question	Yes	No
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 the requested medication.*	☐ Yes (subject to verification) Proceed to question **2**	☐ No Proceed to question **3**
2. **Has the patient's disease severity has improved and stabilized to warrant continued therapy?**	☐ Yes **Sign and date below**	☐ No **STOP** Coverage not approved
3. **Is the patient 12 years of age or older?**	☐ Yes Proceed to question **4**	☐ No **STOP** Coverage not approved
4. **Is the patient's weight 40 kg OR GREATER?**	☐ Yes Proceed to question **5**	☐ No **STOP** Coverage not approved
5. **Was the requested drug prescribed by a dermatologist, allergist, or immunologist?**	☐ Yes Proceed to question **6**	☐ No **STOP** Coverage not approved

6. Does the patient have moderate to severe atopic dermatitis?	☐ Yes Proceed to question **7**	☐ No **STOP** Coverage not approved
7. Does the patient have a contraindication to, intolerability to, or has failed treatment with ONE medication in EACH of the following categories: topical corticosteroids, and topical calcineurin inhibitors?	☐ Yes Proceed to question **8**	☐ No **STOP** Coverage not approved
8. Does the patient have a contraindication to, intolerability to, inability to access treatment, or has the patient failed treatment with Narrowband UVB phototherapy?	☐ Yes Proceed to question **9**	☐ No **STOP** Coverage not approved
9. Is the patient currently receiving another immunobiologic therapy?	☐ 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