PRIOR AUTHORIZATION REQUEST

Adbry

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll-free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please note that supporting clinical documentation is required for **ALL** PA requests.

1	Will the patient be using the requested medication in combination with another monoclonal antibody (for example, Dupixent, Cinqair, Fasenra, Nucala, Tezspire, Xolair)? [If yes, no further questions.]	Yes	No
2	What is the indication or diagnosis? [] Atopic dermatitis (If checked, go to 3) [] Asthma (If checked, no further questions) [] Idiopathic Pulmonary Fibrosis (If checked, no further questions)		

If you have any questions, call: 1-888-258-8250

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	[] Ulcerative Colitis (If checked, no further questions)		
	[] Other (If checked, no further questions)		
3	Is the requested medication being prescribed by or in consultation with an allergist, immunologist, or dermatologist? [If no, no further questions.]	Yes	No
4	Is the patient currently receiving the requested medication? [If no, skip to question 9.]	Yes	No
5	Has the patient been receiving medication samples for the requested medication? [If yes, skip to question 9.]	Yes	No
6	Does the patient have a previously approved PA on file with the current plan? [Note: If the patient does NOT have a previously approved PA on file for the requested medication with the current plan, the renewal request will be considered under initial therapy.] [If no, skip to question 9.]	Yes	No
7	Has the patient already received at least 4 months of therapy with the requested medication? [Note: A patient who has received less than 4 months of therapy or who is restarting therapy with the requested medication should be considered under Initial Therapy.] [If no, skip to question 9.]	Yes	No
8	Does the patient have a documented clinical response to therapy as determined by the prescriber? [Note: Examples of a response to the requested medication are marked improvements in erythema, induration/papulation/edema, excoriations, and lichenification; reduced pruritus; decreased requirement for other topical or systemic therapies; reduced body surface area affected with atopic dermatitis; or other responses observed.] [No further questions.]	Yes	No
9	Is the patient greater than or equal to 12 years of age? [If no, no further questions.]	Yes	No
10	Does the patient have a documented diagnosis of moderate to severe atopic dermatitis? [If no, no further questions.]	Yes	No
11	Does the patient have atopic dermatitis involvement estimated to be greater than or equal to 10% of the body surface area according to the prescriber? [If no, no further questions.]	Yes	No

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12	Has the patient had trial and failure, contraindication or intolerance to ALL the following therapeutic class applied for at least 28 consecutive days: A) TWO medium, medium-high, high-, and/or super-high potency prescription topical corticosteroids (for example, fluocinonide, mometasone furoate), B) Topical calcineurin inhibitors (for example, tacrolimus), AND C) Topical PDE inhibitors (for example, Eucrisa)? [If no, no further questions.]	Yes	No
13	Does the prescribed dosing exceed FDA approved indication? [If yes, no further questions.]	Yes	No
14	Prior to initiation, has the patient completed all age-appropriate vaccinations as recommended by current immunization guidelines?	Yes	No

Please document the diagnoses, symptoms, and/or any other information important to this review:

SECTION B: Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 1-833-896-0656

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

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