GUIDELINES FOR USE

INITIAL CRITERIA (NOTE: FOR RENEWAL CRITERIA SEE BELOW)

1. Does the patient have a diagnosis of moderate to severe atopic dermatitis and meet ALL of the following criteria?
   • The patient is 18 years of age or older
   • Therapy is prescribed by or in consultation with a dermatologist, allergist, or immunologist
   • The patient had a trial of a high or super-high potency topical corticosteroid (e.g., triamcinolone acetonide, fluocinonide, clobetasol propionate, halobetasol propionate) AND one non-steroidal topical immunomodulating agent (e.g., Eucrisa, Opzelura, pimecrolimus, tacrolimus)
   • The patient had a trial of or contraindication to Dupixent (dupilumab)

   If yes, enter two approvals by HICL or GPI-10 for a total of 4 months as follows:
   • FIRST APPROVAL: Approve with an end date of 1 month with a quantity limit of #6mL per 28 days.
   • SECOND APPROVAL: Approve for 3 months (enter a start date of 1 week before the end of the first approval) with a quantity limit of #4mL per 28 days.

   If no, do not approve.

INITIAL DENIAL TEXT: *Some terms are already pre-defined in parenthesis. Please use these definitions if the particular text you need to use does not already have definition(s) in it.

Our guideline named TRALOKINUMAB-LDRM (Adbry) requires the following rule(s) be met for approval:
A. You have moderate to severe atopic dermatitis (a type of skin condition)
B. You are 18 years of age or older
C. Therapy is prescribed by or in consultation with a dermatologist (a type of skin doctor), allergist (a type of allergy doctor), or immunologist (a type of immune system doctor)
D. You had a trial of a high or super-high potency topical corticosteroid (such as triamcinolone acetonide, fluocinonide, clobetasol propionate, halobetasol propionate) AND one non-steroidal topical immunomodulating agent (such as Eucrisa, Opzelura, pimecrolimus, tacrolimus)
E. You had a trial of or contraindication to (harmful for) Dupixent (dupilumab)

Your doctor told us [INSERT PT SPECIFIC INFO PROVIDED]. We do not have information showing you [INSERT UNMET CRITERIA]. This is why your request is denied. Please work with your doctor to use a different medication or get us more information if it will allow us to approve this request.

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GUIDELINES FOR USE (CONTINUED)

RENEWAL CRITERIA

1. Does the patient have a diagnosis of moderate to severe atopic dermatitis AND meet the following criterion?
   - The patient has experienced or maintained improvement in at least two of the following: intractable pruritus, cracking and oozing/bleeding of affected skin, impaired activities of daily living

   If yes, approve for 12 months by HICL or GPI-10 with a quantity limit of #4mL per 28 days.
   If no, do not approve.

RENEWAL DENIAL TEXT: *Some terms are already pre-defined in parenthesis. Please use these definitions if the particular text you need to use does not already have definition(s) in it.

   Our guideline named TRALOKINUMAB-LDRM (Adbry) requires the following rule(s) be met for renewal:
   A. You have moderate to severe atopic dermatitis (a type of skin condition)
   B. You have experienced or maintained improvement in at least two of the following:
      1. Intractable pruritus (a type of skin condition)
      2. Cracking and oozing/bleeding of affected skin
      3. Impaired activities of daily living

   Your doctor told us [INSERT PT SPECIFIC INFO PROVIDED]. We do not have information showing you [INSERT UNMET CRITERIA]. This is why your request is denied. Please work with your doctor to use a different medication or get us more information if it will allow us to approve this request.

RATIONALE
For further information, please refer to the Prescribing Information and/or Drug Monograph for Adbry.

REFERENCES