Ebglyss (lebrikizumab)
Prior Authorization Request Form

Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

MEMBER'S LAST NAME: _____ **MEMBER'S FIRST NAME:** _____

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

☐ **URGENT**

MEMBER INFORMATION		
LAST NAME:	**FIRST NAME:**	
PHONE NUMBER:	**DATE OF BIRTH:**	
STREET ADDRESS:		
CITY:	**STATE:**	**ZIP CODE:**
PATIENT INSURANCE ID NUMBER:		

☐ **MALE** ☐ **FEMALE** **HEIGHT (IN/CM):** _____ **WEIGHT (LB/KG):** _____ **ALLERGIES:** _____

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: PRIMETHERAPEUTICS.COM/NOPP

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): _____
AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: _____

PRESCRIBER INFORMATION		
LAST NAME:	**FIRST NAME:**	
PRESCRIBER SPECIALTY:	**EMAIL ADDRESS:**	
NPI NUMBER:	**DEA NUMBER:**	
PHONE NUMBER:	**FAX NUMBER:**	
STREET ADDRESS:		
CITY:	**STATE:**	**ZIP CODE:**
REQUESTER (if different than prescriber):	**OFFICE CONTACT PERSON:**	

MEDICATION OR MEDICAL DISPENSING INFORMATION			
MEDICATION NAME:			
DOSE/STRENGTH:	**FREQUENCY:**	**LENGTH OF THERAPY/REFILLS:**	**QUANTITY:**
☐ **NEW THERAPY** ☐ **RENEWAL** **IF RENEWAL:** DATE THERAPY INITIATED: DURATION OF THERAPY (SPECIFIC DATES):			

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1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? ☐ **YES** (if yes, complete below) ☐ **NO**		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE)**:**	**DURATION OF THERAPY** (SPECIFY DATES)**:**	**RESPONSE/REASON FOR FAILURE/ALLERGY:**

2. LIST DIAGNOSES:	**ICD-10:**
☐ Atopic Dermatitis ☐ Other diagnosis: _____ ICD-10 Code(s):	

3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.

Will the patient be using the drug as a part of the clinical trial? ☐ **Yes** ☐ **No**

Is the medication being prescribed by one of the following or in consultation with one of the following: ? ☐ **Yes** ☐ **No**

□ **Allergist**
□ **Immunologist**
□ **Dermatologist**

Will Ebglyss (lebrikizumab) be used in combo w Cibinqo (abrocitinib), Olumiant (baracitinib), RinvoqER (upadacitinib), Opzelura (ruxolitinib), Adbry (tralokinumab), Dupixent (dupilumab) or Nemluvio (nemolizumab)? ☐ **Yes** ☐ **No**

Initial Request:
Has the patient tried and failed a 3-month trial of Dupixent (Please submit documentation)?
☐ **Yes** ☐ **No**

For diagnosis of Atopic Dermatitis, answer the following:
Has the patient had the diagnosis of atopic dermatitis for at least 12 months? ☐ **Yes** ☐ **No**
Please submit documentation.

Does the patient have atopic dermatitis on at least 10% or more of their body surface area?
☐ **Yes** ☐ **No Please submit documentation.**

Has the patient tried at least two different topical steroids? ☐ **Yes** ☐ **No**
Please submit documentation.

If patient has not had at least 2 different topical steroids, has the patient tried at least one topical steroid AND one topical calcineurin inhibitor (tacrolimus or pimecrolimus)? ☐ **Yes** ☐ **No**
Please submit documentation.

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If patient has not had at least 2 different topical steroids, has the patient tried at least one topical steroid AND Eucrisa(crisaborole)? ☐ **Yes** ☐ **No Please submit documentation.**

If patient has not had at least 2 different topical steroids, has the patient tried at least one topical steroid AND Zoryve(roflumilast)? ☐ **Yes** ☐ **No Please submit documentation.**

If patient has not had at least 2 different topical steroids, has the patient tried at least one topical steroid AND Vtama(tapinarof)? ☐ **Yes** ☐ **No Please submit documentation.**

Renewal Request:
Is patient continuing to have a positive clinical response? ☐ **Yes** ☐ **No Please submit documentation.**

Is prescriber a immunologist, dermatologist or allergist? ☐ **Yes** ☐ **No**

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Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received.

ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature or Electronic I.D. Verification: _____ **Date:** _____

FAX THIS FORM TO: 800-424-7640
MAIL REQUESTS TO: Prime Therapeutics Management Prior Authorization Program
Attn: CP-4201
P.O. Box 64811
St. Paul, MN 55164-0811
Phone: 877-228-7909