IOWA Health and Human Services

Request for Prior Authorization
Lebrikizumab-lbkz (Ebglyss)

FAX Completed Form To
1 (800) 574-2515
Provider Help Desk
1 (877) 776-1567

(PLEASE PRINT – ACCURACY IS IMPORTANT)

IA Medicaid Member ID #	Patient name	DOB
Patient address		
Provider NPI	Prescriber name	Phone
Prescriber address		Fax
Pharmacy name	Address	Phone
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.		
Pharmacy NPI	Pharmacy fax	NDC

Prior authorization (PA) is required for Ebglyss (lebrikizumab-lbkz). Payment for non-preferred agents will be considered when there is documentation of a previous trial and therapy failure with a preferred agent. Payment will be considered when patient has an FDA approved or compendia indication for the requested drug under the following conditions:

1. **Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and**
2. **Patient's current weight in kilograms (kg) is provided; and**
3. **Patient has a diagnosis of moderate-to-severe atopic dermatitis; and**
   - **a. Patient has failed to respond to good skin care and regular use of emollients; and**
   - **b. Patient has documentation of an adequate trial and therapy failure with one preferred medium to high potency topical corticosteroid for a minimum of 2 consecutive weeks; and**
   - **c. Patient has documentation of an adequate trial and therapy failure with a topical immunomodulator for a minimum of 4 weeks; and**
   - **d. Patient will continue with skin care regimen and regular use of emollients.**

If criteria for coverage are met, initial authorization will be given for 16 weeks to allow for initial dosing. Requests for continuation of therapy will be considered at 12-month intervals with documentation of an adequate response to therapy and dose reduction to maintenance dosing.

The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.

Preferred

☐ Ebglyss

Strength	Usage Instructions	Quantity	Day's Supply
_____	_____	_____	_____

Diagnosis: _____

Patient's current weight in kg: _____ Date Obtained: _____

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Moderate to severe atopic dermatitis

Preferred Medium to High Potency Topical Corticosteroid Trial:

Drug name & dose:_____ Trial dates:_____

Failure reason:_____

Preferred Topical Immunomodulator Trial:

Drug name & dose:_____ Trial dates:_____

Failure reason:_____

Has patient failed to respond to good skin care and regular use of emollients? □ Yes □ No

Will patient continue with skin care regimen and regular use of emollients? □ Yes □ No

<u>Renewal Requests</u>

Document adequate response to therapy: _____

_____

Medical or contraindication reason to override trial requirements:_____

_____

Attach lab results and other documentation as necessary.

Prescriber signature (Must match prescriber listed above.)	Date of submission

IMPORTANT NOTE: *In evaluating requests for prior authorization, the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary, by contact with the county Department of Health and Human Services, that the member continues to be eligible for Medicaid.*