Louisiana Medicaid
Lebrikizumab-lbkz (Ebglyss™)

The *Louisiana Uniform Prescription Drug Prior Authorization Form* should be utilized to request clinical authorization for lebrikizumab-lbkz (Ebglyss™).

Additional Point-of-Sale edits may apply.

By submitting the authorization request, the prescriber attests to the conditions available HERE.

Approval Criteria for Initiation of Therapy

- The recipient is 12 years of age or older on the date of the request; **AND**
- The recipient weighs at least 40 kg (88 lbs) [weight of recipient must be **stated on the request**]; **AND**
- The recipient has a diagnosis of moderate to severe atopic dermatitis (AD); **AND**
- **ONE** of the following:
    - There has been a treatment failure or intolerable side effect with a preferred topical corticosteroid agent (see Dermatology – Steroids, Topical – Low, Medium, High and Very High Potency) (names and dates of medications must be **stated on the request**); **AND**
    - The recipient has a contraindication to **ALL** preferred topical corticosteroid agents; **AND**
- The medication is prescribed by, or the request states that this medication is being prescribed in consultation with, a dermatologist, immunologist or allergist; **AND**
- The prescriber **states on the request** that the medication requested is not prescribed concurrently with another biologic immunomodulator or JAK inhibitor; **AND**
- If request is for a non-preferred agent - **ONE** of the following is required: (see Dermatology – Atopic Dermatitis Immunomodulators on the PDL/NPDL for a list of preferred agents)
    - The recipient has had a *treatment failure* with at least one preferred product; **OR**
    - The recipient has had an *intolerable side effect* to at least one preferred product; **OR**
    - The recipient has *documented contraindication(s)* to all of the preferred products that are appropriate to use for the condition being treated; **OR**
    - There is *no preferred product that is appropriate* to use for the condition being treated.

Approval Criteria for Continuation of Therapy

- The prescriber **states on the request** that there is evidence of a positive response to therapy including a significant reduction in areas affected and/or severity of AD; **AND**
- The prescriber **states on the request** that the medication requested is not prescribed concurrently with another biologic immunomodulator or JAK inhibitor.

Duration of approval for initiation of therapy: 6 months
Duration of approval for continuation of therapy: 12 months

Reference

Ebglyss (lebrikizumab-lbkz) [package insert]. Indianapolis, IN: Eli Lilly and Company; September 2024. https://pi.lilly.com/us/ebglyss-uspi.pdf?s=pi

Revision / Date	Implementation Date
Policy created / November 2024	March 2025