Louisiana Medicaid
Tralokinumab-ldrm (Adbry™)

The *Louisiana Uniform Prescription Drug Prior Authorization Form* should be utilized to request clinical authorization for tralokinumab-ldrm (Adbry™).

Additional Point-of-Sale edits may apply.

*This agent may have **Black Box Warnings**, and/or may be subject to **Risk Evaluation and Mitigation Strategy (REMS)** under FDA safety regulations. Please refer to individual prescribing information for details.*

Approval Criteria

- The recipient is 18 years of age or older on the date of the request; **AND**
- The recipient has a diagnosis of moderate to severe atopic dermatitis (AD); **AND**
- There has been a treatment failure or intolerable side effect with or contraindication to 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 medication is prescribed by, or the request states that this medication is being prescribed in consultation with, a dermatologist, immunologist or allergist; **AND**
- Previous use of a preferred product - **ONE** of the following is required:
    - 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; **AND**
- By submitting the authorization request, the prescriber attests to the following:
    - The prescribing information for the requested medication has been thoroughly reviewed, including any Black Box Warning, Risk Evaluation and Mitigation Strategy (REMS), contraindications, minimum age requirements, recommended dosing, and prior treatment requirements; **AND**
    - All laboratory testing and clinical monitoring recommended in the prescribing information have been completed as of the date of the request and will be repeated as recommended; **AND**
    - The recipient has no concomitant drug therapies or disease states that limit the use of the requested medication and will not be receiving the requested medication in combination with any other medication that is contraindicated or not recommended per FDA labeling.

Reauthorization Criteria

- The recipient continues to meet initial criteria; **AND**

- 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 atopic dermatitis.

Duration of initial and reauthorization approval: 6 months

Reference

Adbry (tralokinumab-ldrm) [package insert]. Madison, NJ: LEO Pharma Inc; December 2021. https://www.leo-pharma.us/Files/Billeder/US%20Website%20Product%20PIs/AdbryPI.pdf

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