Adbry

Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-866-249-6155**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-866-814-5506.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

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Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____
Request Initiated For: _____

1. What is the prescribed dose and frequency?
   a) Loading dose:
   ❑ Adbry 150mg Quantity and Frequency: _____
   ❑ Other: _____
   b) Maintenance dose:
   ❑ Adbry 150 mg Quantity and Frequency: _____
   ❑ Other: _____

2. What is the diagnosis?
   ❑ Atopic dermatitis, moderate-to-severe
   ❑ Other _____

3. What is the ICD-10 code? _____

4. Will the requested medication be used concomitantly with other biologics or JAK inhibitors indicated for atopic dermatitis? ❑ Yes ❑ No

5. Is the patient currently receiving treatment with the requested medication? ❑ Yes ❑ No *If No, skip to #8*

6. Is the patient currently receiving the requested medication through samples or a manufacturer's patient assistance program? *If Yes or Unknown, skip to #8* ❑ Yes ❑ No ❑ Unknown

7. Has the patient achieved or maintained a positive clinical response as evidenced by low disease activity (i.e., clear or almost clear skin) or improvement in signs and symptoms of atopic dermatitis (e.g., redness, itching, oozing/crusting) since starting treatment with the requested medication? ***ACTION REQUIRED: If Yes, please attach supporting documentation (e.g. chart notes) showing that the patient has experienced a positive clinical response to therapy as evidenced by low disease activity or improvement in signs or symptoms.***
   ❑ Yes ❑ No *No further questions*

8. What is the percentage of body surface area (BSA) affected prior to initiation of the requested medication? ***ACTION REQUIRED: Please attach supporting chart note(s) or medical record indicating affected areas and body surface area. _____%*** *If greater than or equal to 10% of BSA, skip to #10.*
9. Are crucial body areas (e.g., hands, feet, face, neck, scalp, genitals/groin, intertriginous areas) affected?

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ACTION REQUIRED: If Yes, please attach supporting chart note(s) or medical record indicating affected area(s). ❑ Yes ❑ No

10. Which topical therapies, if any, has the patient had an inadequate treatment response to in the past year?
ACTION REQUIRED: Please attach supporting chart note(s) or medical record documentation and claims history showing prerequisite therapies including dosage, duration, and response to therapy.
❑ Topical corticosteroid
❑ Topical calcineurin inhibitor, *no further questions*
❑ Both a topical corticosteroid and a topical calcineurin inhibitor, *no further questions*
❑ None of the above, *skip to #12*

11. What is the potency of the highest-potency topical corticosteroid the patient has tried in the past year?
If medium, high or super-high potency, please indicate the active ingredient, strength, and dosage form of medium to super-high potency topical steroid that was tried and no further questions.
❑ Least potent
❑ Low potency
❑ Lower-mid potency
❑ Medium potency: _____
❑ High potency: _____
❑ Super-high potency: _____

12. Is the use of medium to super-high potency topical corticosteroids and topical calcineurin inhibitors not advisable for the patient? ***ACTION REQUIRED: If Yes, please attach supporting documentation of why therapy is not advisable.*** ❑ Yes ***q*** No

APPENDIX: Relative potency of select topical corticosteroid products

Potency	**Drug**	**Dosage form**	**Strength**
I. Super-high potency (group 1)	Augmented betamethasone dipropionate	Ointment, Lotion, Gel	0.05%
	Clobetasol propionate	Cream, Gel, Ointment, Solution, Cream (emollient), Lotion, Shampoo, Foam, Spray	0.05%
	Fluocinonide	Cream	0.1%
	Flurandrenolide	Tape	4 mcg/cm^2
	Halobetasol propionate	Cream, Lotion, Ointment, Foam	0.05%
II. High potency (group 2)	Amcinonide	Ointment	0.1%
	Augmented betamethasone dipropionate	Cream	0.05%
	Betamethasone dipropionate	Ointment	0.05%
	Clobetasol propionate	Cream	0.025%
	Desoximetasone	Cream, Ointment, Spray	0.25%
		Gel	0.05%
	Diflorasone diacetate	Ointment, Cream (emollient)	0.05%
	Fluocinonide	Cream, Ointment, Gel, Solution	0.05%
	Halcinonide	Cream, Ointment	0.1%
	Halobetasol propionate	Lotion	0.01%
Potency	**Drug**	**Dosage form**	**Strength**
III. High potency (group 3)	Amcinonide	Cream, Lotion	0.1%
	Betamethasone dipropionate	Cream, hydrophilic emollient	0.05%
	Betamethasone valerate	Ointment	0.1%
		Foam	0.12%
	Desoximetasone	Cream, Ointment	0.05%
	Diflorasone diacetate	Cream	0.05%

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	Fluocinonide	Cream, aqueous emollient	0.05%
	Fluticasone propionate	Ointment	0.005%
	Mometasone furoate	Ointment	0.1%
	Triamcinolone acetonide	Cream, Ointment	0.5%
IV. Medium potency (group 4)	Betamethasone dipropionate	Spray	0.05%
	Clocortolone pivalate	Cream	0.1%
	Fluocinolone acetonide	Ointment	0.025%
	Flurandrenolide	Ointment	0.05%
	Hydrocortisone valerate	Ointment	0.2%
	Mometasone furoate	Cream, Lotion, Solution	0.1%
	Triamcinolone acetonide	Cream	0.1%
		Ointment	0.05% and 0.1%
		Aerosol Spray	0.2 mg per 2-second spray
V. Lower-mid potency (group 5)	Betamethasone dipropionate	Lotion	0.05%
	Betamethasone valerate	Cream	0.1%
	Desonide	Ointment, Gel	0.05%
	Fluocinolone acetonide	Cream	0.025%
	Flurandrenolide	Cream, Lotion	0.05%
	Fluticasone propionate	Cream, Lotion	0.05%
	Hydrocortisone butyrate	Cream, Lotion, Ointment, Solution	0.1%
	Hydrocortisone probutate	Cream	0.1%
	Hydrocortisone valerate	Cream	0.2%
	Prednicarbate	Cream (emollient), Ointment	0.1%
	Triamcinolone acetonide	Lotion	0.1%
		Ointment	0.025%
VI. Low potency (group 6)	Alclometasone dipropionate	Cream, Ointment	0.05%
	Betamethasone valerate	Lotion	0.1%
	Desonide	Cream, Lotion, Foam	0.05%
	Fluocinolone acetonide	Cream, Solution, Shampoo, Oil	0.01%
	Triamcinolone acetonide	Cream, lotion	0.025%
VII. Least potent (group 7)	Hydrocortisone (base, less than 2%)	Cream, Ointment, Solution	2.5%
		Lotion	2%
		Cream, Ointment, Gel, Lotion, Spray, Solution	1%
		Cream, Ointment	0.5%
	Hydrocortisone acetate	Cream	2.5%
		Lotion	2%
		Cream	1%

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____

Prescriber or Authorized Signature **Date (mm/dd/yy)**

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