STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES
BUREAU FOR MEDICAL SERVICES

Office of Pharmacy Services
Prior Authorization Criteria
Adbry® (tralokinumab)
Effective 5/25/2022

Prior Authorization Request Form

Adbry *(tralokinumab) is an interleukin-13 antagonist indicated for the treatment of moderate-to-severe atopic dermatitis in adult patients whose disease is not adequately controlled with topical prescription therapies or when those therapies are not advisable. ADBRY can be used with or without topical corticosteroids.*

CRITERIA FOR APPROVAL:

1. Prescribed by or in consultation with an allergist, immunologist or dermatologist; **AND**

2. Documented diagnosis of moderate to severe Atopic Dermatitis (AD). Documentation must include the affected BSA, areas of involvement and severity of symptoms; **AND**

3. The patient must be within the age range as recommended by the FDA label and indication; **AND**

4. Affected body surface area is greater than or equal to 10%; **AND**

5. Patient has failed to find relief of symptoms after a minimum of 30-day trials of two agents from the following list in the last 12 months:

   a. Medium to High potency topical corticosteroid*
   b. Elidel
   c. Eucrisa
   d. Tacrolimus

*Trial of medium to high potency topical steroid is required unless the affected area involves sensitive areas such as the face, skin folds or genitals. However, a trial of two other agents among the list above, are still required prior to Adbry approval.

Approval Duration:

Initial approval will be for 3 months.

Criteria for reauthorization:

1. Demonstrate continued documented compliance; **AND**
2. Documentation of satisfactory patient response (including current affected BSA and severity of symptoms) has been provided.

Continuation of therapy will be granted for 12 months.

References:

1.) Lexicomp monograph for tralokinumab (accessed 5/2022)
2.) Adbry package insert