

**Ebglyss™ (Ilebrikizumab-Ibkz) Prior Authorization Form****Member Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ **Member ID#:** \_\_\_\_\_**Drug Information****Pharmacy Billing (NDC: \_\_\_\_\_) Start Date (or date of next dose):** \_\_\_\_\_**Dose:** \_\_\_\_\_ **Regimen:** \_\_\_\_\_**Pharmacy Information****Pharmacy NPI:** \_\_\_\_\_ **Pharmacy Name:** \_\_\_\_\_**Pharmacy Phone:** \_\_\_\_\_ **Pharmacy Fax:** \_\_\_\_\_**Prescriber Information****Prescriber NPI:** \_\_\_\_\_ **Prescriber Name:** \_\_\_\_\_**Prescriber Phone:** \_\_\_\_\_ **Prescriber Fax:** \_\_\_\_\_ **Specialty:** \_\_\_\_\_**Criteria****For Initial Authorization:**

1. Please indicate the diagnosis and information:

 **Moderate-to-Severe Atopic Dermatitis** **Other:** \_\_\_\_\_

2. Is member inadequately controlled with topical prescription therapies? Yes \_\_\_ No \_\_\_

3. Is there a reason topical treatment is not advised? Yes \_\_\_ No \_\_\_

a. If yes, please describe: \_\_\_\_\_

4. Has member failed 1 medium potency to very-high potency Tier-1 topical corticosteroid? Yes \_\_\_ No \_\_\_

a. If yes, please provide the medication and duration of treatment:

i. Drug: \_\_\_\_\_ Date of trial: \_\_\_\_\_

ii. Was the trial at least 2 weeks in duration? Yes \_\_\_ No \_\_\_

b. If no, is there a contraindication or documented intolerance to those medications? Yes \_\_\_ No \_\_\_

i. If yes, please describe: \_\_\_\_\_

5. Has member failed 1 topical calcineurin inhibitor (e.g., pimecrolimus, tacrolimus)? Yes \_\_\_ No \_\_\_

a. If yes, please provide the medication and duration of treatment:

i. Drug: \_\_\_\_\_ Date of trial: \_\_\_\_\_

ii. Was the trial at least 2 weeks in duration? Yes \_\_\_ No \_\_\_

b. If no, is there a contraindication or documented intolerance to those medications? Yes \_\_\_ No \_\_\_

i. If yes, please describe: \_\_\_\_\_

6. Member's weight: \_\_\_\_\_ kg

7. Member's body surface area (BSA) of atopic dermatitis involvement: \_\_\_\_\_

**(Page 1 of 2)****PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:**University of Oklahoma College of Pharmacy  
Pharmacy Management Consultants  
Product Based Prior Authorization UnitFax: 1-800-224-4014  
Phone: 1-800-522-0114 Option 4**CONFIDENTIALITY NOTICE**

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**Ebglyss™ (Ilebrikizumab-Ibkz) Prior Authorization Form****Member Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ **Member ID#:** \_\_\_\_\_**Criteria****For Initial Authorization: (continued)**

8. Is Ebglyss® prescribed by a dermatologist, allergist, or immunologist or has the member been evaluated by a dermatologist, allergist, or immunologist within the last 12 months (or an advanced care practitioner with a supervising physician who is a dermatologist, allergist, or immunologist)? Yes \_\_\_ No \_\_\_
9. Will Ebglyss® be used concurrently with other biologic medications? Yes \_\_\_ No \_\_\_
- a. If yes, please provide details and patient-specific information to support the concurrent use:

\_\_\_\_\_  
\_\_\_\_\_Additional Information: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_**For Continued Authorization:**

1. Date of last dose: \_\_\_\_\_
2. Is the member responding well to treatment? Yes \_\_\_ No \_\_\_
3. Is the member compliant with therapy? Yes \_\_\_ No \_\_\_

Additional Information: \_\_\_\_\_  
\_\_\_\_\_**(Page 2 of 2)****Prescriber Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_***I certify that the indicated treatment is medically necessary and all information is true and correct to the best of my knowledge. Failure to complete this form in full will result in processing delays.*****PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:**University of Oklahoma College of Pharmacy  
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