BlueCross BlueShield
Federal Employee Program

ADBRY
PRIOR APPROVAL REQUEST

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

Adbry

(tralokinumab-ldrm)

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

NOTE: Form must be completed in its **entirety** for processing

Is this request for brand or generic? ❑Brand ❑Generic

1. Does the patient have a diagnosis of atopic dermatitis (eczema)? ❑Yes ❑No

2. Will the patient be given live vaccines while on this therapy? ❑Yes ❑No

3. Will this medication be used in combination with another non-topical Prior Authorization (PA) medication for atopic dermatitis? ❑Yes* ❑No

   If YES, please specify the medication: _____

   Non-Topical PA Medications: Cibinqo (abrocitinib), Dupixent (dupilumab), Rinvoq (upadactinib)

4. Has the patient been on this medication continuously for the last **2 months** excluding samples? ***Please select answer below:***

   ❑**NO** – this is **INITIATION** of therapy, please answer the following questions:

   a. Does the patient have moderate to severe atopic dermatitis (eczema)? ❑Yes ❑No

   b. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to a topical calcineurin inhibitor? ❑Yes ❑No

   c. **Age 12-17**: Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to a topical corticosteroid? ❑Yes ❑No

   d. **Age 18 or older**: Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to a **HIGH** potency topical corticosteroid? ❑Yes ❑No

   e. Which strength is being requested? ***Please select answer below and indicate quantity:***

   ❑**150 mg prefilled syringe:** Please specify the requested quantity: _____ syringes for 112 days (16 weeks)

   ❑**300 mg autoinjector:** Please specify the requested quantity: _____ autoinjectors for 112 days (16 weeks)

   ❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following questions:

   a. Has the patient's condition improved or stabilized with therapy? ❑Yes ❑No

   b. Which strength is being requested? ***Please select answer below and indicate quantity:***

   ❑**150 mg prefilled syringe:** Please specify the requested quantity: _____ syringes every 84 days

   ❑**300 mg autoinjector:** Please specify the requested quantity: _____ autoinjectors every 84 days

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Message:

Attached is a Prior Authorization request form.

For your convenience, there are 3 ways to complete a Prior Authorization request:

Electronically Online (ePA) Results in 2-3 **minutes** **FASTEST AND EASIEST**	Now you can get responses to drug Prior Authorization requests **securely** online. **Online** submissions may receive **instant** responses and do not require faxing or phone calls. Requests can be made 24 hours a day, 7 days a week. For more information on electronic prior authorization (ePA) and to register, go to **Caremark.com/ePA.**
Phone (4-5 **minutes** for response)	The FEP Clinical Call Center can be reached at **(877)-727-3784** between the hours of 7AM-9PM Eastern Time. A live representative will assist with the Prior Authorization, asking for the same information contained on the attached form. Please review the form and have your answers ready for faster service. The process over the phone takes on average between 4 and 5 minutes.
Fax (3-5 **days** for response)	Fax the attached form to **(877)-378-4727**. Requests sent via fax will be processed and responded to within 5 business days. The form must be filled out completely, if there is any missing information the Prior Authorization request cannot be processed. ***Please only fax the completed form once as duplicate submissions may delay processing times.***