Adbry® (tralokinumab-ldrm)
Effective 09/01/2022

Plan	☒ MassHealth ☐Commercial/Exchange	**Program Type**	☒ Prior Authorization ☐ Quantity Limit ☐ Step Therapy
Benefit	☒ Pharmacy Benefit ☐ Medical Benefit (NLX)		
Specialty Limitations	This medication has been designated specialty and must be filled at a contracted specialty pharmacy.		
Contact Information	**Specialty Medications**		
	All Plans	Phone: 866-814-5506	Fax: 866-249-6155
	Non-Specialty Medications		
	MassHealth	Phone: 877-433-7643	Fax: 866-255-7569
	Commercial	Phone: 800-294-5979	Fax: 888-836-0730
	Exchange	Phone: 855-582-2022	Fax: 855-245-2134
	Medical Specialty Medications (NLX)		
	All Plans	Phone: 844-345-2803	Fax: 844-851-0882
Exceptions	N/A		

Overview
Adbry® (tralokinumab-ldrm) an interleukin (IL)-13 antagonist indicated for the treatment of moderate-to-severe atopic dermatitis (AD) in adult patients whose disease is not adequately controlled with topical prescription therapies or when those therapies are not advisable.

Coverage Guidelines
Authorization may be reviewed on a case by case basis for members who are new to the plan currently receiving treatment with requested medication excluding when the product is obtained as samples or via manufacturer's patient assistance programs.

OR

Authorization may be granted for members when all the following criteria are met, and documentation is provided:

1. Member is ≥18 years of age
2. Diagnosis of moderate-to-severe atopic dermatitis
3. Prescriber is a specialist (i.e., allergist/immunologist or dermatologist) or consult notes from a specialist are provided
4. Paid claims or physician documentation of inadequate response or adverse reaction to ONE superpotent or potent topical corticosteroid, or contraindication to ALL superpotent or potent topical corticosteroids
5. Paid claims or physician documentation of inadequate response or adverse reaction to topical tacrolimus or Eucrisa® (crisaborole), or contraindication to both topical tacrolimus and Eucrisa® (crisaborole)
6. Appropriate dosing

Continuation of Therapy
Reauthorizations by prescriber will infer a positive response to therapy.

Limitations
1. Initial approvals will be granted for 6 months.
2. Reauthorizations will be granted for 12 months.

References

1. Adbry® [package insert]. Madison (NJ): Leo Pharma Inc.; 2022 Jan.
2. Weston WL, Howe W. Atopic dermatitis (eczema): Pathogenesis, clinical manifestations and diagnosis. In: Basow DS (Ed). UpToDate [database on the internet]. Waltham (MA): UpToDate; 2022 [cited 2022 Mar 22]. Available from: http://www.utdol.com/utd/index.do
3. Howe W. Treatment of atopic dermatitis (eczema). In: Basow DS (Ed). UpToDate [database on the internet]. Waltham (MA): UpToDate; 2022 [cited 2022 Mar 22]. Available from: http://www.utdol.com/utd/index.do
4. Eichenfield LF, Tom WL, Berger TG, Krol A, Paller AS, Schwarzenberger K, et al. Guidelines of care for the management of atopic dermatitis: section 2. Management and treatment of atopic dermatitis with topical therapies. J Am Acad Dermatol. 2014 Jul;71(1):116-32.
5. Sidbury R, Davis DM, Cohen DE, Cordoro KM, Berger TG, Bergman JN, et al; American Academy of Dermatology. Guidelines of care for the management of atopic dermatitis: section 3. Management and treatment with phototherapy and systemic agents. J Am Acad Dermatol. 2014 Aug;71(2):327-49.
6. Wollenberg A, Blauvelt A, Guttman-Yassky E, Worm M, Lynde C, Lacour JP, et al. Tralokinumab for moderate-to-severe atopic dermatitis: results from two 52-week, randomized, double-blind, multicentre, placebo-controlled phase III trials (ECZTRA 1 and ECZTRA 2). Br J Dermatol. 2021 Mar;184(3):437-449.

Review History
09/21/22 – Created for Sept P&T. Matched MH criteria. Effective 09/01/2022.

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