UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

Program Number	2024 P 1380-4
Program	Prior Authorization/Notification
Medication	Adbry™ (tralokinumab-ldrm)
P&T Approval Date	2/2022, 2/2023, 3/2023, 3/2023
Effective Date	6/1/2024

1. Background:

Adbry (tralokinumab-ldrm) is an interleukin-13 antagonist indicated for the treatment of moderate to severe atopic dermatitis in patients aged 12 years and older 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.

2. Coverage Criteria[a]:

A. Atopic Dermatitis

1. **Initial Authorization**

a. **Adbry** will be approved based on **all** of the following criteria:

(1) Diagnosis of moderate to severe chronic atopic dermatitis

-AND-

(2) History of failure, contraindication, or intolerance to topical therapies

-AND-

(3) Patient is **not** receiving Adbry in combination with **either** of the following:

(a) Biologic immunomodulator [e.g., Dupixent (dupilumab)]
(b) Janus kinase inhibitor [e.g., Rinvoq (upadacitinib), Xeljanz/XR (tofacitinib), Opzelura (topical ruxolitinib), Cibinqo (abrocitinib)]

Authorization will be issued for 12 months.

2. **Reauthorization**

a. **Adbry** will be approved based on **both** of the following criteria:

(1) Documentation of positive clinical response to Adbry therapy

-AND-

(2) Patient is **not** receiving Adbry in combination with **either** of the following:

(a) Biologic immunomodulator [e.g., Dupixent (dupilumab)]
(b) Janus kinase inhibitor [e.g., Rinvoq (upadacitinib), Xeljanz/XR (tofacitinib), Opzelura (topical ruxolitinib), Cibinqo (abrocitinib)]

Authorization will be issued for 12 months.

[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3. Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may be in place.

4. References:

1. Adbry [package insert]. Madison, NJ: Leo Pharma Inc.; December 2023.

Program	Prior Authorization/Notification - Adbry (tralokinumab-ldrm)
Change Control	
2/2022	New program.
2/2023	Annual review with no changes to coverage criteria. Added state mandate footnote and updated reference.
3/2023	Updated not used in combination criteria.
3/2023	Annual review. Removed age requirement from criteria. Updated background and reference.