STATE OF CONNECTICUT DEPARTMENT OF SOCIAL SERVICES

TELEPHONE: 1-866-409-8386 FAX: 1-866-759-4110

(This and other PA forms are posted on www.ctdssmap.com and can be accessed by clicking on the pharmacy icon)

CT Medical Assistance Program Prior Authorization (PA) Request Form

ADBRY (tralokinumab-ldrm)

Prescriber Information	Patient Information
Prescriber's Name (Last, First):	Member's Name (Last, First):
Prescriber's NPI:	Member's ID:
Prescriber's Phone:	Patient's Date of Birth (MMDDCCYY):
Prescriber's Fax:	
Prescription Information	
Drug Requested:	Quantity Requested:

Clinical Information

Inadequately Controlled Moderate-to-Severe Atopic Dermatitis (Patients aged 12+ years): ▪ Is the patient 12 years of age or older? ▪ Does the patient have a diagnosis of moderate-to-severe atopic dermatitis? ▪ Is their disease not adequately controlled with topical prescription therapy or are those therapies not advisable?	□Yes □No

If you answered "No" to the question for the specific indication above, based on the client age or diagnosis, regarding the medication requested, please provide other information relating to the medical necessity (see Conn. Gen. Stat. § 17b-259b(a)) of this drug for this patient. Submit request, via email, to rx.lmn@ct.gov.

Please Note: Pharmacies should not be contacting prescribers to provide pre-signed PA forms or submitting pre-signed forms for PA, nor should prescribing providers be requesting that pharmacies perform PA activities for them. PA requests must originate from the prescriber, and only the prescriber should sign the form at the time of PA submission.

I certify that documentation is maintained in my files and the information given is true and accurate for the medication requested, subject to penalty under section 17b-99 of the Connecticut General Statutes and sections 17-83k-1- to 17-83k-7, inclusive, of the Regulations of Connecticut State Agencies. I certify that the above-referenced member is a patient under my clinic's/practice's ongoing care. Authorizations for Early Refill Requests are valid one time only.

Signature of Prescriber* ______________________ **Date (MM/DD/CCYY)** ______________

*Mandatory (others may not sign for prescriber). **In accordance with federal law, prescribers must be enrolled in the Connecticut Medical Assistance Program (CMAP). CMAP will not pay for prescriptions written by a non-enrolled provider.**

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