

**Adbry (tralokinumab-ldrm)**  
**Effective 08/16/2026**

|                              |                                                                                                      |                                            |                                                                                  |
|------------------------------|------------------------------------------------------------------------------------------------------|--------------------------------------------|----------------------------------------------------------------------------------|
| <b>Plan</b>                  | <input type="checkbox"/> MassHealth UPPL<br><input checked="" type="checkbox"/> Commercial/Exchange  | <b>Program Type</b>                        | <input checked="" type="checkbox"/> Prior Authorization                          |
| <b>Benefit</b>               | <input checked="" type="checkbox"/> Pharmacy Benefit<br><input type="checkbox"/> Medical Benefit     |                                            | <input type="checkbox"/> Quantity Limit<br><input type="checkbox"/> Step Therapy |
| <b>Specialty Limitations</b> | This medication has been designated specialty and must be filled at a contracted specialty pharmacy. |                                            |                                                                                  |
| <b>Contact Information</b>   | <b>Medical Benefit</b><br><b>Pharmacy Benefit</b>                                                    | Phone: 833-895-2611<br>Phone: 800-711-4555 | Fax: 888-656-6671<br>Fax: 844-403-1029                                           |
| <b>Exceptions</b>            | N/A                                                                                                  |                                            |                                                                                  |

### Overview

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

### Coverage Guidelines

If member is new to the plan (as evidenced by coverage effective date of less than or equal to 90 days), submission of medical records documenting that the member is currently receiving treatment with the requested drug, 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:

1. Diagnosis of moderate to severe atopic dermatitis
2. Member is 12 years of age or older
3. Affected body surface is greater than or equal to 10% body surface area OR crucial body areas (e.g., hands, feet, face, neck, scalp, genitals/groin, intertriginous areas) are affected
4. Member has had a trial and failure of a minimum 30-day supply (14-day supply for topical corticosteroids), intolerance, or contraindication to at least ONE of the following:
  - a. Medium or higher potency topical corticosteroid (see Appendix)
  - b. Pimecrolimus cream
  - c. Tacrolimus ointment
  - d. Eucrisa

### Continuation of Therapy

Requests for reauthorization will be approved when all of the following criteria are met:

1. Submission of medical records (e.g., chart notes) demonstrating a clinical improvement in the member's condition, as evidenced by low disease activity (e.g., clear or almost clear skin), or improvement in signs and symptoms of atopic dermatitis (e.g., redness, itching, oozing/crusting)

## Limitations

1. Initial approvals will be granted for 6 months
2. Reauthorizations will be granted for 12 months
3. The following quantity limits apply:

| Drug Name       | Quantity Limits          |
|-----------------|--------------------------|
| Adbry 150mg/mL  | 4 injections per 28 days |
| Adbry 300 mg/mL | 2 injections per 28 days |

## Appendix

### Appendix: Relative potency of select topical corticosteroid products

| Potency            | Drug                                 | Dosage form                                                                     | Strength              |
|--------------------|--------------------------------------|---------------------------------------------------------------------------------|-----------------------|
| Super-high potency | Augmented betamethasone dipropionate | Ointment, Lotion, Gel                                                           | 0.05%                 |
|                    | Clobetasol propionate                | Cream, Gel, Ointment, Solution, Cream (emollient), Lotion, Shampoo, Foam, Spray | 0.05%                 |
|                    | Fluocinonide                         | Cream                                                                           | 0.1%                  |
|                    | Flurandrenolide                      | Tape                                                                            | 4 mcg/cm <sup>2</sup> |
|                    | Halobetasol propionate               | Cream, Lotion, Ointment, Foam                                                   | 0.05%                 |
| High potency       | Amcinonide                           | Ointment                                                                        | 0.1%                  |
|                    | Augmented betamethasone dipropionate | Cream                                                                           | 0.05%                 |
|                    | Betamethasone dipropionate           | Ointment                                                                        | 0.05%                 |
|                    | Clobetasol propionate                | Cream                                                                           | 0.025%                |
|                    | Desoximetasone                       | Cream, Ointment, Spray                                                          | 0.25%                 |
|                    |                                      | Gel                                                                             | 0.05%                 |
|                    | Diflorasone diacetate                | Ointment, Cream (emollient)                                                     | 0.05%                 |
|                    | Fluocinonide                         | Cream, Ointment, Gel, Solution                                                  | 0.05%                 |
|                    | Halcinonide                          | Cream, Ointment                                                                 | 0.1%                  |
| High potency       | Halobetasol propionate               | Lotion                                                                          | 0.01%                 |
|                    | Amcinonide                           | Cream, Lotion                                                                   | 0.1%                  |
|                    | Betamethasone dipropionate           | Cream, hydrophilic emollient                                                    | 0.05%                 |
|                    | Betamethasone valerate               | Ointment                                                                        | 0.1%                  |
|                    |                                      | Foam                                                                            | 0.12%                 |
|                    | Desoximetasone                       | Cream, Ointment                                                                 | 0.05%                 |
|                    | Diflorasone diacetate                | Cream                                                                           | 0.05%                 |
|                    | Fluocinonide                         | Cream, aqueous emollient                                                        | 0.05%                 |
|                    | Fluticasone propionate               | Ointment                                                                        | 0.005%                |
|                    | Mometasone furoate                   | Ointment                                                                        | 0.1%                  |
| Medium potency     | Triamcinolone acetonide              | Cream, Ointment                                                                 | 0.5%                  |
|                    | Betamethasone dipropionate           | Spray                                                                           | 0.05%                 |
|                    | Clocortolone pivalate                | Cream                                                                           | 0.1%                  |
|                    | Fluocinolone acetonide               | Ointment                                                                        | 0.025%                |



| Potency | Drug                    | Dosage form             | Strength                  |
|---------|-------------------------|-------------------------|---------------------------|
|         | Flurandrenolide         | Ointment                | 0.05%                     |
|         | Hydrocortisone valerate | Ointment                | 0.2%                      |
|         | Mometasone furoate      | Cream, Lotion, Solution | 0.1%                      |
|         | Triamcinolone acetonide | Cream                   | 0.1%                      |
|         |                         | Ointment                | 0.05% and 0.1%            |
|         |                         | Aerosol Spray           | 0.2 mg per 2-second spray |

## References

1. Adbry (tralokinumab-ldrm) [prescribing information]. Madison, NJ: LEO Pharma Inc.; December 2025.

## Review History

06/22/2022 – Created and reviewed for June P&T. Effective 10/01/2022.

09/11/2024 – Reviewed and Updated at September P&T. Updated age requirement from 18 years of age to 12 years of age. Streamlined step through requirements. Added quantity limit for 300 mg/mL strength to the policy. Effective 11/1/2024.

1/8/2025 – Reviewed and updated for January P&T. Updated topical step through requirements to include Eucrisa and added minimal trial length. Updated reauthorization criteria to require documentation of clinical response to therapy. Effective 4/1/2025.

03/12/2025 – Reviewed and updated for March P&T. Updated initial approval length to 6 months. Effective 4/1/2025.

02/11/2026 – Reviewed at February P&T. No clinical changes. Effective 03/01/2026.

03/11/2026 – Reviewed and updated for March P&T. Administrative update - changing verbiage in reauthorization criteria from “documentation is submitted” to “submission of medical records (e.g., chart notes...” and updating language for members who are new to the Plan. Effective 05/01/2026.

08/12/2026 – Reviewed and updated at August P&T. Minor verbiage updates made to reauthorization criteria. Effective 08/16/2026.

