Mass General Brigham
Health Plan

# Ebglyss (lebrikizumab-lbkz)
# Effective 05/01/2026

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

**Overview**

Ebglyss (lebrikizumab-lbkz) is an interleukin-13 antagonist indicated for the treatment of adults and pediatric patients 12 years of age and older who weigh at least 40 kilograms with moderate-to-severe atopic dermatitis whose disease is not adequately controlled with topical prescription therapies or when those therapies are not advisable. Ebglyss 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 when all of the following criteria are met:

1. Diagnosis of moderate to severe atopic dermatitis
2. Member is at least 12 years of age
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 trial and failure of a minimum 30-day supply (14-day supply for topical steroids), 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 (crisaborole) ointment

**<u>Continuation of Therapy</u>**

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

1. Submission of medical records (e.g., chart notes) demonstrating clinical improvement in 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 requests will be approved for 6 months.

2. Reauthorization requests will be approved for 12 months.
3. The following quantity limitations apply:

| Drug Name and Dosage Form | Quantity Limitation |
|---|---|
| Ebglyss 250 mg prefilled syringe | 2 syringes per 28 days |
| Ebglyss 250 mg prefilled pen | 2 pens 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$^2$ |
| | 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% |
| | Halobetasol propionate | Lotion | 0.01% |
| High potency | 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% |
| | Triamcinolone acetonide | Cream, Ointment | 0.5% |
| Medium potency | Betamethasone dipropionate | Spray | 0.05% |
| | Clocortolone pivalate | Cream | 0.1% |

| Potency | Drug | Dosage form | Strength |
|---|---|---|---|
| | Fluocinolone acetonide | Ointment | 0.025% |
| | 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**


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**Review History**

04/09/2025 – Created and reviewed at April P&T. Effective 07/01/2025.
06/11/2025 – Reviewed and Updated at June P&T. Updated quantity limitations. Effective 07/01/2025.
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.