09-J4000-20

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Subject: Tralokinumab-ldrm (Adbry®) Injection

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DESCRIPTION:

Tralokinumab-ldrm (Adbry) is an interleukin-13 (IL-13) antagonist that was approved by the U.S. Food and Drug Administration (FDA) in December 2021 for "the treatment of moderate-to-severe atopic dermatitis in adult patients whose disease is not adequately controlled with topical prescription therapies or when those therapies are not advisable". Tralokinumab is the first IL-13 specific antagonist to be approved by the FDA. Dupilumab (Dupixent), approved for the treatment of atopic dermatitis in March 2017, inhibits both IL-4 and IL-13 by binding to the IL-4R alpha subunit shared by IL-4 and IL-13 receptors. Tralokinumab is a human IgG4 monoclonal antibody that specifically binds to IL-13 and inhibits its interaction with the IL-13 receptor α1 and α2 subunits. IL-13 is a naturally occurring cytokine of the Type 2 immune response. Tralokinumab inhibits IL-13-induced responses including the release of proinflammatory cytokines, chemokines and IgE.

Atopic Dermatitis

Atopic dermatitis (AD), also known as atopic eczema, is a chronic, pruritic inflammatory dermatosis affecting up to 25% of children and 1-5% of adults. AD follows a relapsing course and is associated with elevated serum immunoglobulin (IgE) levels and a personal or family history of type I allergies, allergic rhinitis, and/or asthma. Onset is most common between 3 and 6 months of age, with approximately 60% of patients developing the eruption in the first year of life and 90% by age 5. While the majority of affected individuals have resolution of disease by adulthood, 10 to 30% do not, and a smaller percentage first develop symptoms as adults. AD has a complex pathogenesis involving genetic, immunologic, and environmental factors, which lead to a dysfunctional skin barrier and dysregulation of the immune system. Clinical findings include erythema, edema, xerosis, erosions/excoriations, oozing and crusting, and lichenification. These clinical findings vary by patient age and chronicity of lesions. Pruritus is a hallmark of the condition that is responsible for much of the disease burden borne by

patients and their families. Typical patterns include facial, neck and extensor involvement in infants and children, flexure involvement in any age group, with sparing of groin and axillary regions.

Goals of treatment are to reduce symptoms (pruritus and dermatitis), prevent exacerbations, and minimize therapeutics risks. Despite its relapsing and remitting nature, the majority of patients with AD can achieve clinical improvement and disease control with nonpharmacological interventions (e.g., emollient use), conventional topical therapies (including corticosteroids and calcineurin inhibitors) and environmental and occupational modifications, when necessary. The American Academy of Dermatology (AAD) guidelines suggest application of moisturizers should be an integral part of the treatment of patients with AD as there is strong evidence that their use reduces disease severity and need for pharmacologic intervention. They are an important component of maintenance treatment and prevention of flares. The AAD recommends topical corticosteroids (TCS) for patients who fail to respond to good skin care and regular use of emollients alone. Proactive, intermittent use of topical corticosteroids as maintenance therapy (1-2 times weekly) on areas that commonly flare is recommended to help prevent relapses and is more effective than use of emollients alone. Monitoring by physical exam for cutaneous side effects during long-term, potent steroid use is suggested. Proactive, once to twice weekly application of mid-potency TCS for up to 40 weeks has not demonstrated adverse events (e.g., purpura, telangiectasia, striae, focal hypertrichosis, acneiform/rosacea-like eruptions, skin atrophy) in clinical trials. It is recommended that patients with acute flares use super high or high potency topical corticosteroids for one to two weeks, and then replace these with lower potency preparations until the lesions resolve.14 AAD notes that mid- to higher potency topical corticosteroids are appropriate for short courses to gain rapid control of symptoms, but long-term management should use the least-potent corticosteroid that is effective. In general, if AD is not responding after 2 weeks of treatment, evaluation to determine other treatment plans is indicated.

Topical calcineurin inhibitors (TCIs) (e.g., pimecrolimus, tacrolimus) are recommended by the AAD as second-line therapy and are effective for acute and chronic treatment. They are particularly useful in selected clinical situations such as recalcitrance to steroids; for sensitive areas (face, anogenital, skin folds); for steroid-induced atrophy; and when there is long-term uninterrupted topical steroid use. TCIs are recommended for use on actively affected areas as a steroid-sparing agent. Proactive, intermittent use of TCIs as maintenance therapy (2-3 times per week) on areas that commonly flare is recommended to help prevent relapses while reducing need for topical corticosteroids and is more effective than use of emollients alone. Prescribing information for Elidel (pimecrolimus) cream and Protopic (tacrolimus) ointment indicate evaluation after 6 weeks if symptoms of AD do not improve for adults and pediatrics.

Phototherapy is recommended as a treatment for both acute and chronic AD in children and adults, after failure of the mentioned above. Systemic immunomodulator agents are indicated and recommended for the subset of adult and pediatric patients in whom optimized topical regimens using emollients, topical anti-inflammatory therapies, adjunctive methods, and/or phototherapy do not adequately control the signs and symptoms of disease. Photo therapy and systemic immunomodulating agents may also be used in patients whose medical, physical, and/or psychological states are greatly affected by their skin disease. Oral cyclosporine, azathioprine, methotrexate, and mycophenolate mofetil are the most commonly used systemic immunomodulators and most efficacious for treating AD. The AAD recommends that systemic corticosteroids should be avoided if possible and should exclusively be reserved for acute, severe exacerbations and as a short-term bridge to other systemic, steroid sparing therapies.

Efficacy

The efficacy of Adbry was assessed in three randomized, double-blind, placebo-controlled trials [ECZTRA 1 (NCT03131648), ECZTRA 2 (NCT03160885), and ECZTRA 3 (NCT03363854)]. Efficacy was assessed in a total of 1934 subjects 18 years of age and older with moderate-to-severe atopic dermatitis (AD) not adequately controlled by topical medication(s). Disease severity was defined by an Investigator's Global Assessment (IGA) score greater than or equal to 3 in the overall assessment of AD lesions on a severity scale of 0 to 4, an Eczema Area and Severity Index (EASI) score greater than or equal to 16 on a scale of 0 to 72, and a minimum body surface area (BSA) involvement of greater than or equal to 10%. At baseline, 58% of subjects were male, 69% of subjects were white, 50% of subjects had a baseline IGA score of 3 (moderate AD), and 50% of subjects had a baseline IGA score of 4 (severe AD). The baseline mean EASI score was 32 and the baseline weekly averaged Worst Daily Pruritus Numeric Rating Scale (NRS) was 8 on a scale of 0-10.

In all three trials, subjects received subcutaneous injections of Adbry 600 mg or placebo on Day 0, followed by 300 mg every other week or placebo for 16 weeks. Responders were defined as achieving an IGA 0 or 1 ("clear" or "almost clear") or EASI-75 (improvement of at least 75% in EASI score from baseline) at week 16.

To evaluate maintenance of response in the monotherapy trials (ECZTRA 1 and ECZTRA 2), subjects responding to initial treatment with Adbry 300 mg every other week were re-randomized to Adbry 300 mg every other week, Adbry 300 mg every 4 weeks or placebo every other week for another 36 weeks following first dose administration. Subjects randomized to placebo in the initial treatment period who achieved a clinical response at week 16 continued to receive placebo every other week for another 36 weeks. Non-responders at week 16, and subjects who lost clinical response during the maintenance period were placed on open-label treatment with Adbry 300 mg every other week and optional use of TCS.

The ECZTRA 3 trial studied the use of Adbry in combination with either a topical corticosteroid or topical calcineurin inhibitor. Subjects received either Adbry 300 mg every other week with TCS or placebo with TCS and as needed topical calcineurin inhibitors (TCI) until week 16. Subjects in the Adbry 300 mg with TCS group who achieved clinical response at week 16 were re-randomized to Adbry 300 mg every other week with TCS or Adbry every 4 weeks with TCS for another 16 weeks following first dose administration. Subjects in the placebo with TCS group who achieved clinical response at week 16 continued on placebo with TCS for another 16 weeks. Subjects who did not achieve clinical response at week 16 received Adbry 300 mg every other week for another 16 weeks. A mid-potency TCS (i.e., mometasone furoate 0.1% cream) was dispensed at each dosing visit. Subjects were instructed to apply a thin film of the dispensed TCS as needed once daily to active lesions from week 0 to week 32 and were to discontinue treatment with TCS when control was achieved. An additional, lower potency TCS or TCI could be used at the investigator's discretion on areas of the body where use of the supplied TCS was not advisable, such as areas of thin skin.

All three trials assessed the primary endpoints of the proportion of subjects with an IGA 0 or 1 at week 16 and the proportion of subjects with EASI-75 at week 16. Secondary endpoints included the reduction of Worst Daily Pruritus NRS (weekly average) of at least 4 points on the 11-point itch NRS from baseline to week 16**.**

	ECZTRA 1		ECZTRA 2		ECZTRA 3	
	Adbry 300 mg every other week	**Placebo**	**Adbry 300 mg every other week**	**Placebo**	**Adbry 300 mg every other week + TCS**	**Placebo + TCS**
Number of subjects randomized and dosed (FAS)[a]	601	197	577	193	243	123
IGA 0 or 1[b,c] *Difference from Placebo (95% CI)*	16% *9% (4%,13%)*	7%	21% *12% (7%,17%)*	9%	38% *9% (1%,21%)*	27%
EASI-75[c] *Difference from Placebo (95% CI)*	25% *9%* *(6%,18%)*	13%	33% *9% (17%,28%)*	10%	56% *9% (9%,30%)*	37%
Number of subjects with baseline Worst Daily Pruritus NRS (weekly average) score ≥4	594	194	563	192	240	123
Worst Daily Pruritus NRS (≥4 point reduction)[c] *Difference from Placebo (95% CI)*	20% *10% (4%,15%)*	10%	25% *16% (11%,21%)*	9%	46% *11% (1%,22%)*	35%

a. Full Analysis Set (FAS) includes all subjects randomized and dosed

b. Responders was defined as a subject with an IGA 0 or 1 (“clear” or “almost clear”)

c. Subjects who received rescue treatment or with missing data were considered as non-responders

Note: Difference and 95% CI are based on the CMH test stratified by region and baseline IGA score

A higher proportion of subjects in the Adbry 300 mg every other week arm achieved EASI-90 compared to placebo in the three pivotal trials. Examination of age, gender, race, body weight, and previous treatment, including immunosuppressants, did not identify differences in response to Adbry 300 mg every other week among these subgroups.

In ECZTRA 1, 179 Adbry 300 mg every other week responders (IGA 0/1 or EASI-75) were re-randomized (and dosed) at week 16 to Adbry 300 mg every other week (68 subjects), Adbry 300 mg every 4 weeks (76 subjects) or placebo (35 subjects). Among these subjects, 39 subjects in Adbry 300 mg every other week arm, 36 subjects in Adbry 300 mg every 4 weeks arm and 19 subjects in placebo arm were IGA 0/1 responders at week 16. Maintenance of IGA 0/1 response at week 52 was as follows: 20 subjects (51%) in the every other week arm, 14 subjects (39%) in the every 4 weeks arm and 9 subjects (47%) in the placebo arm. Among the re-randomized subjects, 47 subjects in Adbry 300 mg every other week arm, 57 subjects in Adbry 300 mg every 4 weeks arm and 30 subjects in placebo arm were EASI-75 responders at week 16. Maintenance of EASI-75 response at week 52 was as follows: 28 subjects (60%) in the every other week arm, 28 subjects (49%) in the every 4 weeks arm and 10 subjects (33%) in the placebo arm.

In ECZTRA 2, 218 Adbry 300 mg every other week responders (IGA 0/1 or EASI-75) were re-randomized (and dosed) at week 16 to Adbry 300 mg every other week (90 subjects), Adbry 300 mg every 4 weeks (84 subjects) or placebo (44 subjects). Among these subjects, 53 subjects in Adbry 300 mg every other week arm, 44 subjects in Adbry 300 mg every 4 weeks arm and 26 subjects in placebo arm were IGA 0/1 responders at week 16. Maintenance of IGA 0/1 response at week 52 was as follows: 32 subjects (60%)

in the every other week arm, 22 subjects (50%) in the every 4 weeks arm and 6 subjects (23%) in the placebo arm. Among the re-randomized subjects, 76 subjects in Adbry 300 mg every other week arm, 69 subjects in Adbry 300 mg every 4 weeks arm and 40 subjects in placebo arm were EASI-75 responders at week 16. Maintenance of EASI-75 response at week 52 was as follows: 43 subjects (57%) in the every other week arm, 38 subjects (55%) in the every 4 weeks arm and 8 subjects (20%) in the placebo arm.

In ECZTRA 3, 131 Adbry 300 mg every other week + TCS responders (IGA 0/1 or EASI-75) were re-randomized (and dosed) at week 16 to Adbry 300 mg every other week + TCS (65 subjects) or Adbry 300 mg every 4 weeks + TCS (66 subjects). Among these subjects, 45 subjects in Adbry 300 mg every other week + TCS arm and 46 subjects in Adbry 300 mg every 4 weeks + TCS arm were IGA 0/1 responders at week 16. Maintenance of IGA 0/1 response at week 32 was as follows: 40 subjects (89%) in the every other week arm and 35 subjects (76%) every 4 weeks arm. Among the re-randomized subjects, 65 subjects in Adbry 300 mg every other week arm and 62 subjects in Adbry 300 mg every 4 weeks arm were EASI-75 responders at week 16. Maintenance of EASI-75 response at week 32 was as follows: 60 subjects (92%) in the every other week arm and 56 subjects (90%) in the every 4 weeks arm.

POSITION STATEMENT:

Comparative Effectiveness

The FDA has deemed the drug(s) or biological product(s) in this coverage policy to be appropriate for self-administration or administration by a caregiver (i.e., not a healthcare professional). Therefore, coverage (i.e., administration) in a provider-administered setting such as an outpatient hospital, ambulatory surgical suite, physician office, or emergency facility is not considered medically necessary.

Initiation of tralokinumab-ldrm (Adbry) **meets the definition of medical necessity** when **ALL** of the following criteria are met ("1" to "7"):

1. **ONE** of the following ("a", "b", or "c"):
    a. Information has been provided that indicates the member has been treated with tralokinumab (starting on samples is not approvable) within the past 90 days
    b. The prescriber states the member has been treated with tralokinumab (starting on samples is not approvable) within the past 90 days **AND** is at risk if therapy is changed
    c. Tralokinumab will be used for the treatment of an indication listed in the Table, and **ALL** of the indication-specific criteria are met
2. **EITHER** of the following ("a" or "b"):
    a. The member's age is within FDA labeling for the requested indication for tralokinumab
    b. The prescriber has provided information in support of using tralokinumab for the member's age for the requested indication
3. **ONE** of the following ("a", "b", or "c"):
    a. The member is initiating therapy with tralokinumab
    b. The member has been treated with tralokinumab for less than 16 consecutive weeks

c. The member has been treated with tralokinumab for at least 16 consecutive weeks, **AND EITHER** of the following ("i" or "ii"):

   i. The member weighs less than 100 kg, and **ONE** of the following:

      - The member has achieved clear or almost clear skin **AND** the patient's dose will be reduced to 300 mg every 4 weeks
      - The member has **NOT** achieved clear or almost clear skin
      - The prescriber has provided information in support of therapy using 300 mg every 2 weeks

   ii. The member weighs greater than or equal to 100 kg

4. The prescriber is a specialist in the area of the member's diagnosis (e.g., dermatologist, allergist, immunologist), **OR** the prescriber has consulted with a specialist in the area of the member's diagnosis
5. The member will **NOT** be using tralokinumab in combination with another biologic immunomodulator agent (full list in "Other" section); Janus kinase (JAK) inhibitor [Cibinqo (abrocitinib), Olumiant (baricitinib), Opzelura (ruxolitinib), Rinvoq (upadacitinib), Xeljanz (tofacitinib), and Xeljanz XR (tofacitinib extended release)]; Otezla (apremilast); Sotyktu (deucravacitinib); or Zeposia (ozanimod)
6. The member does **NOT** have any FDA labeled contraindications to Adbry
7. **ONE** of the following ("a" or "b"):

   a. The requested quantity (dose) does **NOT** exceed the following:

      i. Loading dose - 600 mg (four 150 mg injections) x 1 dose

      ii. Maintenance dose – 300 mg (two 150 mg injections) every 2 weeks starting 2 weeks after the loading dose

         - QL: 150 mg/mL pre-filled syringes - 4 syringes (4 mL)/28 days

   b. The requested quantity (dose) is greater than the program quantity limit but does **NOT** exceed the maximum FDA labeled dose **OR** the maximum compendia-supported dose (i.e., DrugDex with 1 or 2a level of evidence, AHFS, or NCCN compendium 1 or 2a recommended use) for the requested indication, **AND** the requested quantity (dose) cannot be achieved with a lower quantity of a higher strength and/or package size that does not exceed the program quantity limit

TABLE 1

Indications and Specific Criteria	
Indication	**Specific Criteria**
Moderate-to-severe atopic dermatitis (AD)	When **ALL** of the following are met ("1" to "5"): 1. **ONE** of the following: a. The member has at least 10% body surface area involvement **OR**

	b. The member has involvement of the palms and/or soles of the feet **AND** 2. **ONE** of the following: a. The member has tried and had an inadequate response to an oral systemic immunosuppressant (e.g., methotrexate, azathioprine, mycophenolate mofetil, cyclosporine) used for a minimum of 3 months for the treatment of AD **OR** b. The member has an intolerance or hypersensitivity to an oral systemic immunosuppressant **OR** c. The member has tried and had an inadequate response to **BOTH** at least a mid-potency topical steroid used for a minimum of 4 weeks **AND** a topical calcineurin inhibitor (e.g., Elidel/pimecrolimus, Protopic/tacrolimus) used for a minimum of 6 weeks **OR** d. The member has an intolerance or hypersensitivity to **BOTH** at least a mid-potency topical steroid **AND** a topical calcineurin inhibitor **OR** e. The member has an FDA labeled contraindication to **ALL** oral systemic immunosuppressants, mid-potency topical steroids, **AND** topical calcineurin inhibitors **AND** 3. The prescriber has assessed the member's baseline (prior to therapy with tralokinumab) pruritus and other symptom severity (e.g., erythema, edema, xerosis, erosions/excoriations, oozing and crusting, and/or lichenification) **AND** 4. The member will be using standard maintenance therapy (e.g., topical emollients, good skin care practices) in combination with tralokinumab
Other indications	The member has another FDA-approved indication for tralokinumab **OR** an indication supported in DrugDex with 1 or 2a level of evidence, AHFS, or NCCN compendium 1 or 2a recommended use for tralokinumab
Approval duration: 6 months (loading dose approved for 1 month, then maintenance dose approved for the remainder of 6 months)	

Continuation of tralokinumab-ldrm (Adbry) **meets the definition of medical necessity** when **ALL** of the following criteria are met ("1" to "6"):

1. An authorization or reauthorization for tralokinumab has been previously approved by Florida Blue
2. **EITHER** of the following ("a", "b", or "c"):
    a. The member has a diagnosis of moderate-to-severe atopic dermatitis, **AND BOTH** of the following ("i" and "ii"):
        i. The member has had a reduction or stabilization from baseline (prior to therapy with tralokinumab) of **ONE** of the following:
            - Affected body surface area
            - Flares
            - Pruritus, erythema, edema, xerosis, erosions/excoriations, oozing and crusting, and/or lichenification
        ii. The member will continue standard maintenance therapies (e.g., topical emollients, good skin care practices) in combination with tralokinumab
    b. The member has another FDA-approved indication for tralokinumab **OR** an indication supported in DrugDex with 1 or 2a level of evidence, AHFS, or NCCN compendium 1 or 2a recommended use for tralokinumab; **AND** has had clinical benefit with tralokinumab
3. **ONE** of the following ("a", "b", or "c"):
    a. The member is initiating therapy with tralokinumab
    b. The member has been treated with tralokinumab for less than 16 consecutive weeks
    c. The member has been treated with tralokinumab for at least 16 consecutive weeks, **AND EITHER** of the following ("i" or "ii"):
        i. The member weighs less than 100 kg, and **ONE** of the following:
            - The member has achieved clear or almost clear skin **AND** the patient's dose will be reduced to 300 mg every 4 weeks
            - The member has **NOT** achieved clear or almost clear skin
            - The prescriber has provided information in support of therapy using 300 mg every 2 weeks
        ii. The member weighs greater than or equal to 100 kg
4. The prescriber is a specialist in the area of the member's diagnosis (e.g., dermatologist, allergist, immunologist), **OR** the prescriber has consulted with a specialist in the area of the member's diagnosis
5. The member will **NOT** be using tralokinumab in combination with another biologic immunomodulator agent (full list in "Other" section); Janus kinase (JAK) inhibitor [Cibinqo (abrocitinib), Olumiant (baricitinib), Opzelura (ruxolitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Xeljanz (tofacitinib), and Xeljanz XR (tofacitinib extended release)]; Otezla (apremilast); Sotyktu (deucravacitinib); or Zeposia (ozanimod)
6. The member does **NOT** have any FDA-labeled contraindications to Adbry

7. **ONE** of the following ("a" or "b"):
    a. The requested quantity (dose) does **NOT** exceed 300 mg (two 150 mg injections) every 2 weeks
        - QL: 150 mg/mL pre-filled syringes - 4 syringes/28 days
    b. The requested quantity (dose) is greater than program's quantity limit but does **NOT** exceed the maximum FDA labeled dose **OR** the maximum compendia-supported dose (i.e., DrugDex with 1 or 2a level of evidence, AHFS, or NCCN compendium recommended use 1 or 2a) for the requested indication, **AND** the requested quantity (dose) cannot be achieved with a lower quantity of a higher strength and/or package size that does not exceed the program quantity limit

Approval duration: 12 months

DOSAGE/ADMINISTRATION:

THIS INFORMATION IS PROVIDED FOR INFORMATIONAL PURPOSES ONLY AND SHOULD NOT BE USED AS A SOURCE FOR MAKING PRESCRIBING OR OTHER MEDICAL DETERMINATIONS. PROVIDERS SHOULD REFER TO THE MANUFACTURER'S FULL PRESCRIBING INFORMATION FOR DOSAGE GUIDELINES AND OTHER INFORMATION RELATED TO THIS MEDICATION BEFORE MAKING ANY CLINICAL DECISIONS REGARDING ITS USAGE.

FDA-approved

- Tralokinumab is indicated for the treatment of moderate-to-severe atopic dermatitis in adult patients whose disease is not adequately controlled with topical prescription therapies or when those therapies are not advisable. Tralokinumab can be used with or without topical corticosteroids. Topical calcineurin inhibitors may be used, but should be reserved for problem areas only, such as the face, neck, intertriginous and genital areas.
- The recommended subcutaneous injection dosage is:
    - An initial dose of 600 mg (four 150 mg injections), followed by 300 mg (two 150 mg injections) administered every other week.
    - After 16 weeks of treatment, for patients with body weight below 100 kg who achieve clear or almost clear skin, a dosage of 300 mg every 4 weeks may be considered.

Dose Adjustments

- Hepatic Impairment - Specific guidelines for dosage adjustments in hepatic impairment are not available; it appears that no dosage adjustments are needed.
- Renal Impairment - Specific guidelines for dosage adjustments in renal impairment are not available; it appears that no dosage adjustments are needed.

Drug Availability

- Pack sizes containing 2 or 4 prefilled syringes (150 mg/mL) with needle guard

PRECAUTIONS:

Boxed Warning

- None

Contraindications

- Known hypersensitivity to tralokinumab or any of its excipients

Precautions/Warnings

- **Hypersensitivity** - Hypersensitivity reactions including anaphylaxis and angioedema, have been reported with use. If a serious hypersensitivity reaction occurs, discontinue immediately and initiate appropriate therapy.
- **Conjunctivitis and Keratitis** - Conjunctivitis and keratitis occurred more frequently in atopic dermatitis subjects who received tralokinumab. Conjunctivitis was the most frequently reported eye disorder. Most subjects with conjunctivitis or keratitis recovered or were recovering during the treatment period. Advise patients to report new onset or worsening eye symptoms to their healthcare provider.
- **Parasitic (Helminth) Infections** - Patients with known helminth infections were excluded from participation in clinical studies. It is unknown if tralokinumab will influence the immune response against helminth infections by inhibiting IL-13 signaling. Treat patients with pre-existing helminth infections before initiating treatment with tralokinumab. If patients become infected while receiving tralokinumab and do not respond to antihelminth treatment, discontinue treatment with tralokinumab until the infection resolves.
- **Risk of Infection with Live Vaccines** - Tralokinumab may alter a patient's immunity and increase the risk of infection following administration of live vaccines. Prior to initiating therapy with tralokinumab, complete all age-appropriate vaccinations according to current immunization guidelines. Avoid use of live vaccines in patients treated with tralokinumab. Limited data are available regarding coadministration of tralokinumab with non-live vaccines.
- **Immunogenicity** - Across all trial periods, the Anti-Drug-Antibodies (ADA) incidence for subjects who received tralokinumab was 4.6%; 0.9% had persistent ADA and 1% had neutralizing antibodies. No clinically meaningful differences in the pharmacokinetics, safety, or efficacy of tralokinumab were observed in patients who tested positive for anti-tralokinumab antibody (including neutralizing antibodies).
- **Pregnancy -** There are limited data from the use of tralokinumab in pregnant women to inform a drug-associated risk of adverse developmental outcomes. Refer to the product label for more information.
- **Lactation** - There are no data on the presence of tralokinumab in human milk, the effects on the breastfed infant, or the effects on milk production. Refer to the product label for more information.

BILLING/CODING INFORMATION:

HCPCS Coding

L20.0	Besnier's prurigo
L20.81	Atopic neurodermatitis
L20.82	Flexural eczema
L20.84	Intrinsic (allergic) eczema
L20.89	Other atopic dermatitis

L20.9	Atopic dermatitis, unspecified

ICD-10 Diagnosis Codes That Support Medical Necessity

J3590	Unclassified biologics

REIMBURSEMENT INFORMATION:

Refer to section entitled **POSITION STATEMENT**.

PROGRAM EXCEPTIONS:

Federal Employee Program (FEP): Follow FEP guidelines.

State Account Organization (SAO): Follow SAO guidelines.

Medicare Part D: Florida Blue has delegated to Prime Therapeutics authority to make coverage determinations for the Medicare Part D services referenced in this guideline.

Medicare Advantage: No National Coverage Determination (NCD) and/or Local Coverage Determination (LCD) were found at the time of the last guideline review date.

DEFINITIONS:

Eczema Area Severity Index score (EASI) - assesses severity (severity score) and body surface area affected by erythema, induration/papulation/edema, excoriations, and lichenification (area score), which are graded systematically for each of 4 anatomical regions (head and neck, trunk, upper limbs, lower limbs) and assembled in a composite score, with a score range of 0 to 72.

- EASI 50 - a percentage improvement of EASI score from baseline that is ≥50%
- EASI 75 - a percentage improvement of EASI score from baseline that is ≥75%
- EASI 90 - a percentage improvement of EASI score from baseline that is ≥90%

Helper T cells (a.k.a., CD4+ T cells) – a type of lymphocyte or white blood cell (WBC) that matures in the thymus and play an important role in cell-mediated immunity. T helper cells assist other WBCs in immunologic processes by releasing T cell cytokines. Different types of T helper cells secrete different cytokines (e.g., type 2 release IL-4, IL-5, IL-9, IL-10 and IL-13)

Patient-Oriented Eczema Measure (POEM) – a validated questionnaire, examining seven items (scored 0 to 4 based on frequency of event), used in clinical settings to assess time spent with symptoms and the impact of symptoms on sleep, with a score range of 0 to 28.

Pruritus – itching

Scoring Atopic Dermatitis (SCORAD) - the extent and severity of AD over the body area and the severity of 6 specific symptoms (erythema, edema/papulation, excoriations, lichenification, oozing/crusts, and dryness) are assessed and scored by the investigator. Subjective assessment of itch and sleeplessness is scored by the patient. The SCORAD score is a combined score of body area affected, and investigator and patient symptom scoring, with a score range of 0 to103.

RELATED GUIDELINES:

Dupilumab (Dupixent), 09-J2000-80
Upadacitinib (Rinvoq), 09-J3000-51

OTHER:

Biologic Immunomodulator Agents Not Permitted as Concomitant Therapy

Actemra (tocilizumab)
Adbry (tralokinumab-ldrm)
Arcalyst (rilonacept)
Avsola (infliximab-axxq)
Benlysta (belimumab)
Cimzia (certolizumab)
Cinqair (reslizumab)
Cosentyx (secukinumab)
Dupixent (dupilumab)
Enbrel (etanercept)
Entyvio (vedolizumab)
Fasenra (benralizumab)
Humira (adalimumab)
Ilaris (canakinumab)
Ilumya (tildrakizumab-asmn)
Inflectra (infliximab-dyyb)
Infliximab
Kevzara (sarilumab)
Kineret (anakinra)
Nucala (mepolizumab)
Orencia (abatacept)
Remicade (infliximab)
Renflexis (infliximab-abda)
Riabni (rituximab-arrx)
Rituxan (rituximab)
Rituxan Hycela (rituximab/hyaluronidase human)
Ruxience (rituximab-pvvr)
Siliq (brodalumab)
Simponi (golimumab)
Simponi Aria (golimumab)
Skyrizi (risankizumab-rzaa)

Stelara (ustekinumab)

Taltz (ixekizumab)

Tezspire (tezepelumab-ekko)

Tremfya (guselkumab)

Truxima (rituximab-abbs)

Tysabri (natalizumab)

Xolair (omalizumab)

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COMMITTEE APPROVAL:

This Medical Coverage Guideline (MCG) was approved by the Florida Blue Pharmacy Policy Committee on 11/09/22.

GUIDELINE UPDATE INFORMATION:

04/01/22	New Medical Coverage Guideline.
06/15/22	Revision to the guideline consisting of updating the position statement to remove the prerequisite use of dupilumab (Dupixent).
01/01/23	Review and revision to guideline consisting of updating the position statement, other section, and references. New drugs were added to the list of drugs that are not permitted for use in combination.