UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

Program Number	2025 P 1472-1
Program	Prior Authorization/Notification
Medication	Ebglyss™ (lebrikizumab-lbkz)
P&T Approval Date	3/2025
Effective Date	5/1/2025

1. Background:

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 kg 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.

2. Coverage Criteria[a]:

A. Atopic Dermatitis

1. **Initial Authorization**

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

(1) Diagnosis of moderate to severe atopic dermatitis

-AND-

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

-AND-

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

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

Authorization will be issued for 12 months.

2. **Reauthorization**

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

(1) Documentation of positive clinical response to Ebglyss therapy

-AND-

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

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

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. Ebglyss [package insert]. Indianapolis, IN: Eli Lilly and Company; September 2024.

Program	Prior Authorization/Notification - Ebglyss (lebrikizumab-lbkz)
Change Control	
3/2025	New program.