Documentation Checklist for Patients With Atopic Dermatitis

This checklist is a guide provided by AbbVie that can help you complete the patient's required prior authorization (PA) form. It (1) may include certain PA criteria which are not necessary for a specific payer and (2) may not include all necessary PA requirements for a specific payer.

Patient Information

First name: ____________ **Middle name:** ____________ **Last name:** ____________ **DOB:** ____________

☐ **Initial Authorization Request** ☐ **Reauthorization Request** ☐ Patient 12 years of age or older

Physician name: ____________ Date: ____________

Specialty: ☐ Allergy ☐ Dermatology ☐ Immunology ☐ Other: ____________

Atopic Dermatitis Diagnosis: ICD-10-CM codes[1] *(select one)*

☐ **L20.8:** Other atopic dermatitis	☐ **L20.9:** Atopic dermatitis, unspecified

Initial Treatment Authorization *(Include all relevant photos of affected areas on the body)*

Body surface area (BSA) affected: ________ % or are any sensitive areas affected? ☐ No ☐ Yes

If yes, please specify: ☐ Hands ☐ Feet ☐ Genitals/groin ☐ Scalp ☐ Other: ____________

☐ Applicable documentation supporting BSA included with submission

Most recent test results, with supporting documentation, included with submission: ☐ Tuberculosis test ☐ Complete blood count (CBC) ☐ Liver enzymes

Disease severity score(s): ☐ Eczema Area and Severity Index (EASI): ________ ☐ Numerical Rating Score (NRS) for Itch Severity: ____________

☐ Investigator Global Assessment (IGA): ________ ☐ Other: ____________

Supplemental Documentation

Impact on Quality of Life

Daily Function: ____________ Mental Health: ____________

Academics/career: ____________ Sleep: ____________

Family/social life: ____________ Additional information: ____________

Quality of Life Scoring Tools

☐ SCORAD (SCORing Atopic Dermatitis)

☐ Dermatology Life Quality Index (DLQI) Total Score

Treatment History *Drug Class*	*Drug Name*	*Dose*	*Duration* *(start and end date)*	*Outcome*
Topical therapies: ☐ Calcineurin inhibitor ☐ Corticosteroid ☐ PDE4 inhibitor ☐ JAK inhibitor ***Systemic therapies:*** ☐ Corticosteroid (intramuscular/oral) ☐ IL antagonist ☐ Immunosuppressant ☐ JAK inhibitor ☐ Phototherapy				☐ Effective ☐ Intolerant ☐ Failed ☐ Contraindicated
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Will any of the above therapies continue to be used by the patient? ☐ No ☐ Yes If yes, list drug name(s) that will be used: ____________

Important Reminder: Certain drugs cannot be used in combination with other drugs. Clearly document which drug(s), if any, will be continued with the drug being requested.

Treatment Reauthorization

How long has the patient been on the requested therapy? List full duration (start date): ____________

Has the patient experienced an improvement in disease severity/activity (eg, impacted BSA, erythema, lichenification)? ____________

Has the patient experienced an improvement in symptoms (eg, reduced itching, redness, oozing)? ____________

Has the patient experienced improvements in quality of life (daily function, social life, mental health)? ____________

Will any other therapies for atopic dermatitis be used in combination with/continued by the patient? ☐ No ☐ Yes If yes, list drug name(s) that will be continued:

____

Listed below are examples of the drug classes used for the treatment of atopic dermatitis. This is not a comprehensive list. Some medications listed below are not approved for the treatment of atopic dermatitis.

Topical Examples

Calcineurin inhibitor		
pimecrolimus (Elidel®)	tacrolimus (Protopic®)	
Corticosteroid		
amcinonide (Cyclocort®)	diflorasone diacetate (Psorcon®)	halcinonide (Halog®)
betamethasone (Diprolene®, Luxiq®)	fluocinolone acetonide (Synalar®)	halobetasol (Ultravate®)
clobetasol (Clobevate®, Olux®, Temovate®)	fluocinonide (Vanos®)	mometasone (Elocon®)
clocortolone (Cloderm®)	flurandrenolide (Cordran®)	triamcinolone (Aristocort® A, Kenalog® Cream, Trianex®)
desoximetasone (Topicort®)	fluticasone (Beser™, Cutivate®)	
Phosphodiesterase-4 (PDE4) inhibitor		
crisaborole (Eucrisa®)		
Topical janus kinase (JAK) inhibitor		
ruxolitinib (Opzelura®)		

Systemic Examples

Corticosteroid (intramuscular)	
betamethasone (Celestone® Soluspan®)	methylprednisolone (Depo-Medrol®)
triamcinolone (Kenalog®)	
Corticosteroid (oral)	
methyprednisolone (Medrol®)	prednisone
Immunosuppressant	
azathioprine (Imuran®)	methotrexate (Trexall®)
cyclosporine (Gengraf®, Neoral®)	mycophenolic acid (CellCept®, Myfortic®)
Interleukin (IL) antagonist	
dupilumab (Dupixent®)	lebrikizumab-lbkz (Ebglyss™)
tralokinumab-ldrm (Adbry®)	
JAK inhibitor	
abrocitinib (Cibinqo™)	upadacitinib (Rinvoq®)

List any reason the patient is unable to take a particular medication (eg, contraindications, comorbidities, lifestyle): _____

_____

_____

The listed drugs are for example purposes only and do not include all potential options; specific required drugs or drug classes will vary based upon the payer's formulary.

This information is presented for informational purposes only and is not intended to provide reimbursement or legal advice. The information presented here does not guarantee payment or coverage. Providers are encouraged to contact third-party payers for specific information about their coverage policies.

Reference: 1. Centers for Medicare & Medicaid Services. 2024 ICD-10-CM. 2024 Code Tables, Tabular and Index. Updated June 29, 2023. Accessed October 10, 2024. https://www.cms.gov/files/zip/2024-code-tables-tabular-and-index-updated-06/29/2023.zip