STATE OF WEST VIRGINIA
DEPARTMENT OF HUMAN SERVICES
BUREAU FOR MEDICAL SERVICES

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Office of Pharmacy Services
Prior Authorization Criteria
Ebglyss® (lebrikizumab-lbkz)
Effective 11/19/2025

Prior Authorization Form

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.

CRITERIA FOR APPROVAL:

1. Must be prescribed by an M.D./D.O. or a specialty trained prescriber with a clinical specialty certification/degree in allergy, immunology, or dermatology; **AND**

2. Documented diagnosis of moderate to severe atopic dermatitis (AD). Documentation must include the affected body surface area (BSA), areas of involvement, and severity of symptoms; **AND**

3. The patient must be within the age range as recommended by the Food and Drug Administration (FDA) label and indication; **AND**

4. Affected body surface area is greater than or equal to 10%; **AND**

5. Patient has failed to find relief of symptoms after a minimum 30-day trial of two agents from the following list in the last 12 months:

    a. Medium to High potency topical corticosteroid*
    b. Elidel
    c. Eucrisa
    d. Tacrolimus

*Trial of medium to high potency topical steroid is required unless the affected area involves sensitive areas such as the face, skin folds or genitals. However, a trial of two other agents among the list above are still required prior to Ebglyss approval.

Approval Duration: Initial approval will be for 3 months.

Criteria for Reauthorization:

1. Demonstrate continued documented compliance; **AND**

2. Documentation of satisfactory patient response (including current affected BSA and severity of symptoms) has been provided.

Continuation of therapy will be granted for 12 months.