

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 codes¹ (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	Quality of Life Scoring Tools
Daily Function: _____ Mental Health: _____	<input type="checkbox"/> SCORAD (SCORing Atopic Dermatitis)
Academics/career: _____ Sleep: _____	<input type="checkbox"/> Dermatology Life Quality Index (DLQI) Total Score
Family/social life: _____ Additional information: _____	

Treatment History Drug Class	Drug Name	Dose	Duration (start and end date)	Outcome
Topical therapies: <input type="checkbox"/> Calcineurin inhibitor <input type="checkbox"/> Corticosteroid <input type="checkbox"/> PDE4 inhibitor <input type="checkbox"/> JAK inhibitor Systemic therapies: <input type="checkbox"/> Corticosteroid (intramuscular/oral) <input type="checkbox"/> IL antagonist <input type="checkbox"/> Immunosuppressant <input type="checkbox"/> JAK inhibitor <input type="checkbox"/> Phototherapy				<input type="checkbox"/> Effective <input type="checkbox"/> Intolerant <input type="checkbox"/> Failed <input type="checkbox"/> 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: _____

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.

Documentation Checklist for Patients With Atopic Dermatitis (cont)

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)	
methylprednisolone (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.

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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>