

**Nemluvio® (nemolizumab-ilto) Prior Authorization Form**

Member Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Member ID#: \_\_\_\_\_

**Drug Information**

Pharmacy billing (NDC: \_\_\_\_\_) Start Date (or date of next dose): \_\_\_\_\_

Dose: \_\_\_\_\_ Regimen: \_\_\_\_\_

**Pharmacy Information**

Pharmacy NPI: \_\_\_\_\_ Pharmacy Name: \_\_\_\_\_

Pharmacy Phone: \_\_\_\_\_ Pharmacy Fax: \_\_\_\_\_

**Prescriber Information**

Prescriber NPI: \_\_\_\_\_ Prescriber Name: \_\_\_\_\_

Prescriber Phone: \_\_\_\_\_ Prescriber Fax: \_\_\_\_\_ Specialty: \_\_\_\_\_

**Criteria****For Initial Authorization:****1. Please indicate the diagnosis and information:**

- Moderate-to-Severe Atopic Dermatitis  
 Prurigo Nodularis (PN)  
 Other: \_\_\_\_\_

A. Has the member failed 1 medium potency to very-high potency Tier-1 topical corticosteroid?

Yes \_\_\_ No \_\_\_

i. If yes, please provide the medication and duration of treatment:

a. Drug: \_\_\_\_\_ Date of trial: \_\_\_\_\_

b. Was the trial at least 2 weeks in duration? Yes \_\_\_ No \_\_\_

ii. If no, is there a contraindication or documented intolerance to medium potency to very-high potency Tier-1 topical corticosteroids? Yes \_\_\_ No \_\_\_

a. If yes, please describe: \_\_\_\_\_

B. Has the member failed 1 topical calcineurin inhibitor [e.g., Elidel® (pimecrolimus), Protopic® (tacrolimus)]?

Yes \_\_\_ No \_\_\_

i. If yes, please provide the medication and duration of treatment:

a. Drug: \_\_\_\_\_ Date of trial: \_\_\_\_\_

b. Was the trial at least 2 weeks in duration? Yes \_\_\_ No \_\_\_

ii. If no, is there a contraindication or documented intolerance to topical calcineurin inhibitors?

Yes \_\_\_ No \_\_\_

a. If yes, please describe: \_\_\_\_\_

C. Will Nemluvio® be used concurrently with other biologic medications? Yes \_\_\_ No \_\_\_

i. If yes, please provide patient-specific information to support the concurrent use: \_\_\_\_\_

**(Page 1 of 2)****PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:**University of Oklahoma College of Pharmacy  
Pharmacy Management Consultants  
Product Based Prior Authorization UnitFax: 1-800-224-4014  
Phone: 1-800-522-0114 Option 4**CONFIDENTIALITY NOTICE**

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**Nemluvio<sup>®</sup> (nemolizumab-ilto) Prior Authorization Form**

Member Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Member ID#: \_\_\_\_\_

**Criteria****For Initial Authorization: (continued)**

2. If diagnosis is **Moderate-to-Severe Atopic Dermatitis**, please provide the following:
- A. Is diagnosis adequately controlled with topical prescription therapies? Yes \_\_\_ No \_\_\_
  - B. Does member agree to continue using a topical corticosteroid and/or a topical calcineurin inhibitor in combination with Nemluvio<sup>®</sup> until the disease has sufficiently improved? Yes \_\_\_ No \_\_\_
  - C. Member's body surface area (BSA) of atopic dermatitis involvement: \_\_\_\_\_ Date taken: \_\_\_\_\_
  - D. Is Nemluvio<sup>®</sup> prescribed by a dermatologist, allergist, or immunologist? Yes \_\_\_ No \_\_\_
    - i. If no, has the member been evaluated by a dermatologist, allergist, or immunologist within the last 12 months (or an advanced care practitioner with a supervising physician who is a dermatologist, allergist, or immunologist)? Yes \_\_\_ No \_\_\_
3. If diagnosis is **Prurigo Nodularis (PN)**, please provide the following:
- A. Member's weight: \_\_\_\_\_ Date Taken: \_\_\_\_\_
  - B. Member's Peak Pruritus Numeric Rating Scale (PP-NRS) score: \_\_\_\_\_
  - C. Does the member have  $\geq 20$  PN lesions? Yes \_\_\_ No \_\_\_
  - D. Have all other causes of pruritus been ruled out? Yes \_\_\_ No \_\_\_
  - E. Is Nemluvio<sup>®</sup> prescribed by a dermatologist, allergist, or immunologist? Yes \_\_\_ No \_\_\_
    - i. If no, has the member been evaluated by a dermatologist, allergist, or immunologist for PN within the last 12 months (or an advanced care practitioner with a supervising physician who is a dermatologist, allergist, or immunologist)? Yes \_\_\_ No \_\_\_
  - F. Please provide a patient-specific, clinically significant reason why the member cannot use Dupixent<sup>®</sup>:  
\_\_\_\_\_

**For Continued Authorization:**

- 1. Date of last dose: \_\_\_\_\_
  - 2. Is the member responding well to treatment with Nemluvio<sup>®</sup>? Yes \_\_\_ No \_\_\_
  - 3. Has the member experienced any adverse drug reactions related to Nemluvio<sup>®</sup> therapy? Yes \_\_\_ No \_\_\_
- If yes, please specify adverse reactions: \_\_\_\_\_

Additional Information: \_\_\_\_\_

**(Page 2 of 2)****Prescriber Signature: \_\_\_\_\_ Date: \_\_\_\_\_****I certify that the indicated treatment is medically necessary and all information is true and correct to the best of my knowledge. Failure to complete this form in full will result in processing delays.**PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:University of Oklahoma College of Pharmacy  
Pharmacy Management Consultants  
Product Based Prior Authorization UnitFax: 1-800-224-4014  
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