iowa total care | Iowa Health Link Iowa HHS | Hawki Iowa HHS

Fax Completed Form To
1.833.404.2392
Prescriber Help Desk
1.833.587.2012
Online
covermymeds.com/main/prior-authorization-forms/

Request for Prior Authorization
Nemolizumab-ilto (Nemluvio)
(PLEASE PRINT – ACCURACY IS IMPORTANT)

IA Medicaid Member ID #	Patient name	DOB
Patient address		
Provider NPI	Prescriber name	Phone
Prescriber address		Fax
Pharmacy name	Address	Phone
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.		
Pharmacy NPI	Pharmacy fax	NDC

Prior authorization (PA) is required for Nemluvio (nemolizumab-ilto). Payment for non-preferred agents will be considered when there is documentation of a previous trial and therapy failure with a preferred agent. Payment will be considered when patient has an FDA approved or compendia indication for the requested drug under the following conditions:

1. **Request adheres to all FDA approved labeling for requested drug and indication including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and**
2. **Patient's current weight in kilograms (kg) is provided; and**
3. **Patient has a diagnosis of moderate-to-severe atopic dermatitis; and**
   a. **Patient has failed to respond to good skin care and regular use of emollients; and**
   b. **Patient has documentation of an adequate trial and therapy failure with one preferred medium to high potency topical corticosteroid for a minimum of 2 consecutive weeks; and**
   c. **Patient has documentation of a previous trial and therapy failure with a topical immunomodulator for a minimum of 4 weeks; and**
   d. **For initial therapy, will be used in combination with a topical corticosteroid and/or topical immunomodulator; and**
   e. **Patient will continue with skin care regimen and regular use of emollients; or**
4. **Patient has a diagnosis of moderate to severe prurigo nodularis (PN); and**
   a. **Patient has experienced severe to very severe pruritis, as demonstrated by a current Worst Itch-Numeric Rating Scale (WI-NRS) ≥ 7; and**
   b. **Patient has ≥ 20 nodular lesions (attach documentation); and**
   c. **Documentation of a previous trial and therapy failure with a high or super high potency topical corticosteroid for at least 14 consecutive days.**

If criteria for coverage are met, initial authorizations will be given for 16 weeks to assess the response to therapy. Requests for continuation of therapy will be considered at 12-month intervals with documentation of an adequate response to therapy and a dose reduction to maintenance dosing, where appropriate.

The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.

Non-Preferred

☐ Nemluvio

Strength	Usage Instructions	Quantity	Day's Supply

Diagnosis: _____

Patient's current weight in kg: _____ Date obtained: _____

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☐ **Moderate-to-Severe Atopic Dermatitis**

Did patient fail to respond to good skin care and regular use of emollients? ☐ Yes ☐ No

Will patient continue skin care regimen and regular use of emollients? ☐ Yes ☐ No

Preferred medium to high potency topical corticosteroid trial:

Drug name & dose:_____ Trial dates:_____

Failure reason:_____

Topical immunomodulator trial:

Drug name & dose:_____ Trial dates:_____

Failure reason:_____

Will Nemluvio be used in combination with a topical corticosteroid and/or topical immunomodulator for initial therapy?

☐ Yes (document agent to be used): _____

☐ No

☐ **Moderate to Severe Prurigo Nodularis (PN)**

Worst Itch-Numeric Rating Scale (WI-NRS) response: _____ Date obtained: _____

Does patient have ≥ 20 nodular lesions? ☐ Yes (provide documentation) ☐ No

Preferred high or super high potency topical corticosteroid trial:

Drug name & dose:_____ Trial dates:_____

Failure reason:_____

Renewal requests:

Document adequate response to therapy:_____

_____

Attach lab results and other documentation as necessary.

Prescriber signature (Must match prescriber listed above.)	Date of submission

IMPORTANT NOTE: *In evaluating requests for prior authorization, the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary, by contact with the county Department of Health and Human Services, that the member continues to be eligible for Medicaid.*