SENTARA COMMUNITY PLAN
(MEDICAID)

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: Nemluvio® (nemolizumab-ilto)

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight (if applicable): _____ **Date weight obtained:** _____

Quantity Limit: 1 pen per 28 days

***The Health Plan considers the concomitant use of Nemluvio® with other monoclonal antibody therapies (e.g., Adbry™, Cinqair®, Dupixent®, Fasenra®, Nucala®, Tezspire™, Xolair®) & Janus Kinase (JAK) Inhibitors (oral or topical) (e.g., Cibinqo®, Opzelura™, Rinvoq®, Xeljanz® IR/XR) to be experimental and investigational. Safety and efficacy of these combinations have NOT been established and will NOT be permitted. In the event a member has an active authorization on file for a monoclonal antibody therapy or JAK inhibitor drug, all subsequent requests for Nemluvio® will NOT be approved.**

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

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❑ **Diagnosis: Prurigo Nodularis**
Dosing SubQ:
- **Adult patients weighing less than 90 kg:** Initial dose of 60 mg (two 30 mg injections), followed by 30 mg given every 4 weeks
- **Adult Patients Weighing 90 kg or More:** Initial dose of 60 mg (two 30 mg injections), followed by 60 mg given every 4 weeks

Initial Authorization: 12 months

- ❑ Member is 18 years of age or older
- ❑ Member has a diagnosis of prurigo nodularis (PN)
- ❑ Provider submit member's current weight: _____
- ❑ Member has an 8-week trial and failure of Dupixent®

❑ **Diagnosis: Atopic Dermatitis**
Dosing SubQ: 60 mg followed by 30 mg every 4 weeks. In patients who achieve clear or almost clear skin after 16 weeks of therapy, a dose of 30 mg every 8 weeks is recommended.

Initial Authorization: 12 months

- ❑ Member is 12 years of age or older
- ❑ Member has a diagnosis of moderate to severe atopic dermatitis
- ❑ Prior documented trial and failure of 8 weeks of each the following:
  - ❑ One (1) topical corticosteroid of medium to high potency (e.g., mometasone, triamcinolone)
  - ❑ One (1) topical calcineurin inhibitor (tacrolimus or pimecrolimus)
  - ❑ Trial and failure of Dupixent®

Medication being provided by Specialty Pharmacy - PropriumRx

Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.*