OKLAHOMA Health Care Authority

State of Oklahoma SoonerCare

SoonerSelect | aetna

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 cortiscosteroids? 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: _____

_____

_

Fax completed prior authorization request form to 888-601-8461 or submit Electronic Prior Authorization throughCoverMyMeds® or SureScripts. All requested data must be provided. Incomplete forms or forms without the chart notes will be returned. Pharmacy Coverage Guidelines are available at AetnaBetterHealth.com/Oklahoma.

OKLAHOMA Health Care Authority

State of Oklahoma SoonerCare

SoonerSelect | aetna

Nemluvio® (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® until the disease has sufficiently improved? Yes☐ No☐
   C. Member's body surface area (BSA) of atopic dermatitis involvement: _____ Date taken: _____
   D. Is Nemluvio® 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☐
   E. Please provide a patient-specific, clinically significant reason why the member cannot use Adbry®, Dupixent®, and Ebglyss®: _____
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 ≥20 PN lesions? Yes☐ No☐
   D. Have all other causes of pruritus been ruled out? Yes☐ No☐
   E. Is Nemluvio® 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®:
   _____

For Continued Authorization:

1. Date of last dose:_____
2. Is the member responding well to treatment with Nemluvio®? Yes☐ No☐
3. Has the member experienced any adverse drug reactions related to Nemluvio® therapy? Yes☐ No☐

*If yes, please specify adverse reactions:*_____

Additional Information:_____

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.*

Fax completed prior authorization request form to 888-601-8461 or submit Electronic Prior Authorization throughCoverMyMeds® or SureScripts. All requested data must be provided. Incomplete forms or forms without the chart notes will be returned. Pharmacy Coverage Guidelines are available at AetnaBetterHealth.com/Oklahoma.	CONFIDENTIALITY NOTICE *This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.*