

**Request for Prior Authorization
Nemolizumab-ilto (Nemluvio)**

(PLEASE PRINT – ACCURACY IS IMPORTANT)

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 \geq 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
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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.