US Family Health
Prior Authorization Request Form for
Nemolizumab-ilto (Nemluvio)

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be faxed to 855-273-5735

OR

The patient may attach the completed form to the prescription and **mail** it to:
Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? **Call 1-877-880-7007**

Clinical documentation may be required for approval

Prior Authorization does not expire.

Step 1 **Please complete patient and physician information** (please print):

Patient Name:		Physician Name:	
Address:		Address:	
Sponsor ID #		Phone #:	
Date of Birth:		Secure Fax #:	

Step 2 **Please complete the clinical assessment:**

1. Is the patient 18 years of age or older?	☐ Yes Proceed to question **2**	☐ No **STOP** **Coverage not approved**
2. Is the requested medication being prescribed by an allergist, immunologist, or dermatologist?	☐ Yes Proceed to question **3**	☐ No **STOP** **Coverage not approved**
3. What is the indication or diagnosis?	☐ Prurigo nodularis – Proceed to Question **4** ☐ Other diagnosis – **STOP - Coverage not approved**	
4. Does the patient have 20 or more identifiable nodular lesions in total on both arms, and/or both legs, and/or trunk?	☐ Yes Proceed to question **5**	☐ No **STOP** **Coverage not approved**
5. Has the patient experienced pruritus for 6 weeks or longer?	☐ Yes Proceed to question **6**	☐ No **STOP** **Coverage not approved**
6. Is the patient's prurigo nodularis medication-induced or secondary to a non-dermatologic condition?	☐ Yes Proceed to question **7**	☐ No Proceed to question **8**

7. Has the secondary cause of prurigo nodularis been identified and adequately managed?	☐ Yes Proceed to question **8**	☐ No **STOP** **Coverage not approved**
8. Does the patient have a contraindication to, intolerability to, or has failed treatment with one high potency/class 1 topical corticosteroid (for example, clobetasol propionate 0.05% ointment/cream, fluocinonide 0.05% ointment/cream)?	☐ Yes Proceed to question **9**	☐ No **STOP** **Coverage not approved**
9. Does the patient have a contraindication to, intolerability to, inability to access treatment, or has failed treatment with phototherapy?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**

Step 3

I certify the above is true to the best of my knowledge. Please sign and date:

Prescriber Signature _____ Date _____