USFHP 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**

**https://www.usfamilyhealth.org/for-providers/pharmacy-information/**

**Prior Authorization does not expire for Prurigo nodularis. PA expires in 1 year for atopic dermatitis indication. Initial TRICARE PA approval required for renewal. If renewal criteria met, coverage will be approved indefinitely.**

**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 requested medication being prescribed by an allergist, immunologist, or dermatologist?** | ☐ Yes<br>Proceed to question **2** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **2. What is the indication or diagnosis?** | ☐ Prurigo nodularis – Proceed to Question **3**<br>☐ Moderate to severe atopic dermatitis - Proceed to Question **10**<br>☐ Other diagnosis – **STOP - Coverage not approved** | |
| **3. Is the patient 18 years of age or older?** | ☐ Yes<br>Proceed to question **4** | ☐ No<br>**STOP**<br>**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<br>Proceed to question **5** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **5. Has the patient experienced pruritus for 6 weeks or longer?** | ☐ Yes<br>Proceed to question **6** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **6. Is the patient's prurigo nodularis medication-induced or secondary to a non-dermatologic condition?** | ☐ Yes<br>Proceed to question **7** | ☐ No<br>Proceed to question **8** |

| | | |
|---|---|---|
| **7. Has the secondary cause of prurigo nodularis been identified and adequately managed?** | ☐ Yes<br>Proceed to question **8** | ☐ No<br>**STOP**<br>**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<br>Proceed to question **9** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **9. Does the patient have a contraindication to, intolerability to, inability to access treatment, or has failed treatment with phototherapy?** | ☐ Yes<br>**Sign and date below** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **10. Has the patient received this medication under the TRICARE benefit in the last 6 months?** *Please choose "No" if the patient did not previously have a TRICARE approved PA for the requested medication.* | ☐ Yes<br>Proceed to question **16** | ☐ No<br>Proceed to question **11** |
| **11. How old is the patient?** | ☐ Less than 12 years old - **STOP Coverage not approved**<br>☐ 12 to 17 years of age – Proceed to question **12**<br>☐ 18 years of age or older– Proceed to question **13** | |
| **12. Does the patient have a contraindication to, intolerability to, OR has failed treatment with any topical corticosteroid?** | ☐ Yes<br>Proceed to question **14** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **13. Does the patient have a contraindication to, intolerability to, OR has failed treatment with high potency/class 1 topical corticosteroids (for example, clobetasol propionate 0.05% ointment/cream, fluocinonide 0.05% ointment/cream)?** | ☐ Yes<br>Proceed to question **14** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **14. Does the patient have a contraindication to, intolerability to, OR has failed treatment with topical calcineurin inhibitor (for example, pimecrolimus, tacrolimus)?** | ☐ Yes<br>Proceed to question **15** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **15. Does the patient have a contraindication to, intolerability to, inability to access treatment, OR has failed treatment with Narrowband UVB phototherapy?** | ☐ Yes<br>**Sign and date below** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **16. Has the patient's disease severity improved and stabilized to warrant continued therapy?** | ☐ Yes<br>**Sign and date below** | ☐ No<br>**STOP**<br>**Coverage not approved** |

**Step 3** **I certify the above is true to the best of my knowledge.** Please sign and date:

Prescriber Signature _____ Date _____