maryland physicians care
Medicaid with a Heart

PRIOR AUTHORIZATION REQUEST

Nemluvio

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll-free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please note that supporting clinical documentation is required for **ALL** PA requests.

1	Is the request an INITIAL or CONTINUATION of therapy? [] Initial (If checked, go to 7) [] Continuation (If checked, go to 2)		
2	Is the patient currently receiving the requested medication? [If no, skip to question 7.]	Yes	No
3	Has the patient been receiving medication samples of Nemluvio? [If yes, skip to question 7.]	Yes	No

If you have any questions, call: 1-888-258-8250

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4	Does the patient have a previously approved prior authorization (PA) on file with the current plan? [Note: If the patient does NOT have a previously approved PA on file for the requested medication with the current plan, the renewal request will be considered under initial therapy.] [If no, skip to question 7.]	Yes	No
5	Will the patient be concurrently receiving the requested medication in combination with any monoclonal antibody, anti-IL4, anti-IL5, or TSLP inhibitor such as Adbry, Cinqair, Dupixent, Fasenra, Nucala, Tezspire, or Xolair? [If yes, no further questions.]	Yes	No
6	Has the patient been taking the requested medication for at least 4 months and has experienced a clinically significant benefit from the medication, as documented by the prescriber? ACTION REQUIRED: Submit supporting documentation. [Note: Atopic dermatitis – Examples of a response to the requested medication are marked improvements in erythema, induration/papulation/edema, excoriations, and lichenification; reduced pruritus; decreased requirement for other topical or systemic therapies; reduced body surface area affected with atopic dermatitis; or other responses observed. Prurigo Nodularis – Prurigo nodularis – Examples of response include: A) Reduced nodular lesion count, B) Decreased pruritus, OR C) Reduced nodular lesion size] [No further questions.]	Yes	No
7	What is the indication or diagnosis? [] Atopic dermatitis (If checked, go to 8) [] Prurigo Nodularis (If checked, go to 24) [] Other (If checked, no further questions)		
8	Is the patient greater than or equal to 12 years of age? [If no, no further questions]	Yes	No
9	Will the patient be concurrently receiving the requested medication in combination with any monoclonal antibody, anti-IL4, anti-IL5, or TSLP inhibitor such Adbry, Cinqair, Dupixent, Fasenra, Nucala, Tezspire, or Xolair? [If yes, no further questions.]	Yes	No
10	Does the patient have a documented diagnosis of moderate to serve atopic dermatitis? [If no, no further questions.]	Yes	No
11	Does the prescribed dosing exceed FDA approved indication? [If yes, no further questions.]	Yes	No

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12	Has documentation been provided to confirm that the patient has an IGA score of greater than or equal to 3 and an EASI score of greater than or equal to 16? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
13	Does the patient have atopic dermatitis involvement estimated to be greater than or equal to 10% of the body surface area (BSA) according to the prescriber? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
14	Does the patient have atopic dermatitis affecting the following areas: hands, face, feet, eyes/eyelids, neck, scalp, skin folds, and/or genitalia? [If no, no further questions.]	Yes	No
15	Has the patient tried at least TWO medium-, medium-high, high-, and/or super-high-potency prescription topical corticosteroids? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions]	Yes	No
16	Has the patient tried tacrolimus ointment? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
17	Were the topical corticosteroids and tacrolimus ointment EACH applied daily for at least 28 consecutive days? [If no, no further questions.]	Yes	No
18	Was inadequate efficacy demonstrated with the topical therapies, according to the prescriber? [If no, no further questions.]	Yes	No
19	Has the patient tried Zoryve? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
20	Was Zoryve applied daily for at least 56 consecutive days? [If no, no further questions.]	Yes	No
21	Was inadequate efficacy demonstrated with Zoryve, according to the prescriber? [If no, no further questions.]	Yes	No
22	Has the patient tried Dupixent for at least 4 months? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
23	Is the requested medication prescribed by or in consultation with an allergist, immunologist, or dermatologist?	Yes	No

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	[No further questions.]		
24	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No
25	Is the requested medication prescribed by or in consultation with an allergist, immunologist, or dermatologist? [If no, no further questions.]	Yes	No
26	Does the patient have greater than equal to 20 identifiable nodular lesions in total on both arms, and/or both legs, and/or trunk? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
27	Has documentation been provided to confirm that the patient has an IGA score of greater than or equal to 3? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
28	Has the patient experienced pruritus for 6 weeks or longer? [f yes, skip to question 31.]	Yes	No
29	Does the patient have a secondary cause of prurigo nodularis that has been identified (such as, medication induced, non- dermatologic condition such as neuropathy or psychiatric disease)? [If no, skip to question 31.]	Yes	No
30	Has the secondary cause been adequately managed according to the prescriber? [If no, no further questions.]	Yes	No
31	Has the patient tried at least TWO high- or super-high-potency prescription topical corticosteroid? [If no, no further questions.]	Yes	No
32	Was each topical corticosteroid applied daily for at least 14 consecutive days? [If no, no further questions.]	Yes	No
33	Was inadequate efficacy demonstrated with the topical corticosteroid therapy, according to the prescriber? [If no, no further questions.]	Yes	No
34	Has the patient tried and failed at least TWO traditional systemic agents for prurigo nodularis for at least 3 months? ACTION REQUIRED: Submit supporting documentation. [Note: Examples include systemic immunosuppressants, topical calcineurin inhibitors, or psoralen plus ultraviolet A light (PUVA).] [If no, no further questions.]	Yes	No

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35	Does the prescribed dosing exceed FDA approved indication? [If yes, no further questions.]	Yes	No
36	Will the patient be concurrently receiving the requested medication in combination with any monoclonal antibody, anti-IL4, anti-IL5, or TSLP inhibitor such as Cinqair, Fasenra, Tezspire, or Xolair?	Yes	No

Please document the diagnoses, symptoms, and/or any other information important to this review:

SECTION B: Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 1-833-896-0656

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

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