TRICARE Prior Authorization Request Form for
nemolizumab-ilto (Nemluvio)

JOHNS HOPKINS
HEALTH PLANS
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FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

USFHP Pharmacy Prior Authorization Form

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

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

[12 February 2025]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: