BlueCross BlueShield Federal Employee Program

NEMLUVIO
PRIOR APPROVAL REQUEST

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		

PHYSICIAN COMPLETES

All approved requests are subject to review by a clinical specialist for final validation and coverage determination once all required documentation has been received. Current utilization, including samples, does not guarantee approval of coverage. SUBMITTING THE PATIENT'S MEDICAL RECORDS IS REQUIRED.

Nemluvio (nemolizumab-ilto)

NOTE: Form must be completed in its **entirety** for processing

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

Is this request for brand or generic? ❑Brand ❑Generic

1. Will the patient be given live vaccines while on this therapy? ❑Yes ❑No
2. What is the patient's diagnosis? **DOCUMENTATION IS REQUIRED: Please ensure that all relevant medical records are submitted along with the correct page number(s).**

❑Prurigo nodularis (PN), **please specify the medical record page number(s). PAGE(s)_____ of _____**

a. **Blue Focus Patient:** This is a non-formulary medication. Please provide all formulary alternative medication(s) that have been tried and failed and specify the medical record page number(s) below:

❑PAGE(s)_____ of _____ Formulary alternative medication(s):_____

_____

❑ The patient has not tried and failed any formulary alternatives.

b. What is the patient's weight? _____ kg **OR** _____ lbs

c. Has the patient been on this medication continuously for the last **3 months** excluding samples? ***Please select answer below:***

❑ **NO** – this is **INITIATION** of therapy, please answer the following questions:

i. Does the patient have a documented baseline evaluation of the condition using the Investigator's Global Assessment (IGA) for prurigo nodularis? ❑Yes***** ❑No

***If YES**, please specify score: _____ **AND** medical record page number(s). **PAGE(s)_____ of _____**

ii. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to a **HIGH** potency topical steroid? ❑Yes* ❑No

***If YES*, please specify the medical record page number(s). PAGE(s)_____ of _____**

iii. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to conventional systemic therapy such as cyclosporine or methotrexate? ***Please select answer below:***

❑Inadequate response* ❑Intolerance or contraindication* ❑Has not tried conventional systemic therapy

***Please specify the medical record page number(s). PAGE(s)_____ of _____**

iv. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to phototherapy? ❑Inadequate response* ❑Intolerance or contraindication* ❑Patient has not tried phototherapy

***Please specify the medical record page number(s). PAGE(s)_____ of _____**

v. How many injections will the patient need for 112 days (16 weeks)? _____ injections for 112 days (16 weeks)

❑ **YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following questions:

i. Has there been a documented improvement of the condition using IGA for prurigo nodularis with a decrease from baseline by at least 2 points? ❑Yes* ❑No

***If YES*, please specify the medical record page number(s). PAGE(s)_____ of _____**

ii. How many syringes will the patient need for a 56 day supply? _____ syringes for 56 days

PLEASE PROCEED TO PAGE 2 FOR ADDITIONAL DIAGNOSES

The information provided on this form will be used to determine the provision of healthcare benefits under a U.S. federal government program, and any falsification of records may subject the provider to prosecution, either civilly or criminally, under the False Claim Acts, the False Statements Act, the mail or wire fraud statutes, or other federal or state laws prohibiting such falsification. **Prescriber Certification:** I certify all information provided on this form to be true and correct to the best of my knowledge and belief. I understand that the insurer may request a medical record if the information provided herein is not sufficient to make a benefit determination or requires clarification and I agree to provide any such information to the insurer. Nemluvio – FEP MD Fax Form Revised 1/1/2026

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PAGE 4 - PHYSICIAN COMPLETES

Patient Name: _____ DOB: _____ Patient ID: R _____

❑Atopic dermatitis (eczema), **please specify the medical record page number(s). PAGE(s)_____ of _____**

a. **Standard/Basic Option Patient:** Has the patient tried and failed Adbry, Ebglyss, or Rinvoq? ***Please select answer below:***

❑ **YES –Please specify the medication(s) and medical record page number(s).**

Medication(s): _____ PAGE(s)_____ of _____

❑ **NO – The patient has not tried and failed any of these medications.**

b. **Standard/Basic Option Patient:** Would you like to switch to a preferred medication? The preferred medications are Adbry, Ebglyss, and Rinvoq. ***Please select answer below:***

❑ **YES –** Please answer the questions below:

i. Please select the requested preferred medication: ❑Ebglyss ❑Rinvoq ❑Adbry 150 mg prefilled syringe ❑Adbry 300 mg autoinjector

ii. Does the prescriber agree to review the plan criteria associated with the requested preferred medication to ensure that the medication is safe and appropriate for the patient? ❑Yes ❑No

❑ **NO –** Do not switch.

❑ **NO –** Do not switch however the patient has a medical exception. **Please specify the medical record page number(s). PAGE(s)_____ of _____**

❑ **NO –** Do not switch however I would like to speak with a medical director to discuss the case. **Please specify the preferred date and time to contact, including the time zone, and the phone number: _____**

_____

c. **Blue Focus Patient:** This is a non-formulary medication. Please provide all formulary alternative medication(s) that have been tried and failed and specify the medical record page number(s) below:

❑**PAGE(s)_____ of _____ Formulary alternative medication(s):_____**

_____

❑ **The patient has not tried and failed any formulary alternatives.**

d. **Blue Focus Patient:** Would you like to switch to the preferred medication? The preferred medication is Ebglyss. ***Please select answer below:***

❑ **YES –** Switch to Ebglyss. Please answer the question below:

i. Does the prescriber agree to review the plan criteria associated with the requested preferred medication to ensure that the medication is safe and appropriate for the patient? ❑Yes ❑No

❑ **NO –** Do not switch.

e. Will this be used in combination with another *****non-topical Prior Authorization (PA) medication for atopic dermatitis? ❑Yes***** ❑No ****If YES***, please specify medication: _____

****Non-Topical PA Medications: Adbry (tralokinumab-ldrm), Cibinqo (abrocitinib), Rinvoq (upadactinib)***

f. Has the patient been on this medication continuously for the last **3 months** excluding samples? ***Please select answer below:***

❑ **NO** – this is **INITIATION** of therapy, please answer the following questions:

i. Is the patient's atopic dermatitis (eczema) moderate to severe? ❑Yes* ❑No

****If YES*, please specify the medical record page number(s). PAGE(s)_____ of _____**

ii. Does the patient have a documented baseline evaluation of the condition using one of the following: Investigator's Static Global Assessment (ISGA), Eczema Area and Severity Index (EASI), Patient-Oriented Eczema Measure (POEM) or Scoring Atopic Dermatitis (SCORAD) index? ❑Yes***** ❑No

****If YES***, please select a scoring tool, provide the score, and specify the medical record page number(s):

❑**Eczema Area and Severity Index (EASI)** **Score**: _____ **PAGE(s)_____ of _____**

❑**Investigator's Static Global Assessment (ISGA)** **Score**: _____ **PAGE(s)_____ of _____**

❑**Patient-Oriented Eczema Measure (POEM)** **Score**: _____ **PAGE(s)_____ of _____**

❑**Scoring Atopic Dermatitis (SCORAD) index** **Score**: _____ **PAGE(s)_____ of _____**

PLEASE PROCEED TO PAGE 3 FOR ADDITIONAL ATOPIC DERMATITIS RELATED QUESTIONS & OTHER DIAGNOSES

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PAGE 4 - PHYSICIAN COMPLETES

Patient Name: _____ DOB: _____ Patient ID: R _____

Atopic dermatitis (eczema) CONTINUED:

iii. **Age 12-17**: Please answer the following questions:

1) Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to a topical corticosteroid such as desonide or hydrocortisone acetate? ❑Yes* ❑No
***If YES*, please specify the medical record page number(s). PAGE(s)_____ of _____**

2) Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to a topical calcineurin inhibitor? ❑Yes* ❑No
***If YES*, please specify the medical record page number(s). PAGE(s)_____ of _____**

iv. **Age 18 or older**: Please answer the following questions:

1) Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to a **HIGH** potency topical corticosteroid such as amcinonide, fluocinonide, or halcinonide? ❑Yes* ❑No
***If YES*, please specify the medical record page number(s). PAGE(s)_____ of _____**

2) Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to a topical calcineurin inhibitor? ❑Yes* ❑No
***If YES*, please specify the medical record page number(s). PAGE(s)_____ of _____**

v. Will this medication be used in combination with a topical corticosteroid and/or calcineurin inhibitor? ❑Yes* ❑No
***If YES*, please specify the medical record page number(s). PAGE(s)_____ of _____**

vi. How many syringes will the patient need for 112 days (16 weeks)? _____ syringes for 112 days (16 weeks)

❑ **YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following question:

i. Which scoring tool was used to obtain the patient's baseline score: Investigator's Static Global Assessment (ISGA), Eczema Area and Severity Index (EASI), Patient-Oriented Eczema Measure (POEM), or Scoring Atopic Dermatitis (SCORAD) index? ***Please select a scoring tool and answer the following question:***

❑**Eczema Area and Severity Index**: Has there been a decrease from baseline by at least 75%? ❑Yes* ❑No
***If YES*, please specify the medical record page number(s). PAGE(s)_____ of _____**

❑**Investigator's Static Global Assessment**: Has there been a decrease from baseline by at least 2 points? ❑Yes* ❑No
***If YES*, please specify the medical record page number(s). PAGE(s)_____ of _____**

❑**Patient-Oriented Eczema Measure**: Has there been a decrease from baseline by at least 3 points? ❑Yes* ❑No
***If YES*, please specify the medical record page number(s). PAGE(s)_____ of _____**

❑**Scoring Atopic Dermatitis index**: Has there been a decrease from baseline by at least 50%? ❑Yes* ❑No
***If YES*, please specify the medical record page number(s). PAGE(s)_____ of _____**

❑**Unknown/Unavailable**

ii. How many syringes will the patient need for a 56 day supply? _____ injections syringes for 56 days

❑Other ***(please specify)***: _____ ***(please answer the following question)***

a. How many syringes will the patient need for 112 days (16 weeks)? _____ syringes for 112 days (16 weeks)

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