

IL-31 INHIBITORS PRIOR AUTHORIZATION REQUEST PRESCRIBER FAX FORM

Only the prescriber may complete this form. This form is for prospective, concurrent, and retrospective reviews.

The following documentation is **REQUIRED**. Incomplete forms will be returned for additional information. For formulary information please visit www.myprime.com. Start saving time today by filling out this form electronically. Visit covermymeds.com to begin using this free service.

What is the priority level of this request?

- Standard review
- Expedited/Urgent review – prescriber certifies that waiting for a standard review could seriously harm the patient's life, health or ability to regain maximum function

Today's Date: _____

PATIENT AND INSURANCE INFORMATION

Date of Service (if differs from Today's Date): _____

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
Patient Address:	City, State, Zip:	Patient Telephone:	
Member ID Number:	Group Number:		

PRESCRIBER/CLINIC INFORMATION

Prescriber Name:	Prescriber NPI#:	Specialty:	Contact Name:
Clinic Name:	Clinic Address:		
City, State, Zip:	Phone #:	Secure Fax #:	

PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST

Patient's Diagnosis:

- Moderate-to-severe atopic dermatitis (AD)
- Prurigo nodularis (PN)
- Other (ICD code, plus description): _____

Medication Requested:	Strength:
Dosing Schedule:	Quantity per Month:

For all requests:

1. What is the patient's weight? _____ (kg)
2. Is the patient currently being treated with the requested agent? Yes No
3. Does the patient have any FDA labeled contraindications to the requested agent? Yes No
If yes, please specify contraindications: _____
4. Is the prescriber a specialist in the area of the patient's diagnosis (e.g., allergist, dermatologist, immunologist) or has the prescriber consulted with a specialist in the area of the patient's diagnosis? Yes No
5. Is the patient's age within FDA labeling for the requested indication for the requested agent? Yes No
If no, please provide support for using the requested agent for the patient's age for the requested indication: _____
6. Please list all reasons for selecting the requested agent for the indicated diagnosis, strength, dosing schedule, and quantity over alternatives (e.g., compendia support, journal articles, contraindications, allergies, history of adverse drug reactions to alternatives, lower dose has been tried, information supporting dose over FDA max). **Please note, documentation may be required:** _____

Please continue to the next page.

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
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For all requests:

7. Will the patient be using the requested agent in combination with another immunomodulatory agent (e.g., TNF inhibitors, JAK inhibitors, IL-4 inhibitors) [Abrilada (adalimumab-afzb), Actemra (tocilizumab), Adalimumab, Adbry (tralokinumab-ldrm), Amjevita (adalimumab-atto), Arcalyst (rilonacept), Avsola (infliximab-axxq), Avtozma (tocilizumab-anoh), Benlysta (belimumab), Bimzelx (bimekizumab-bkzx), Cibirgo (abrocitinib), Cimzia (certolizumab), Cinqair (reslizumab), Cosentyx (secukinumab), Cyltezo (adalimumab-adbm), Dupixent (dupilumab), Ebglyss (lebrikizumab-lbkz), Enbrel (etanercept), Entyvio (vedolizumab), Fasentra (benralizumab), Hadlima (adalimumab-bwwd), Hulio (adalimumab-fkjp), Humira (adalimumab), Hyrimoz (adalimumab-adaz), Idacio (adalimumab-aacf), Illaris (canakinumab), Ilumya (tildrakizumab-asmn), Imuldosa (ustekinumab-srlf), Inflectra (infliximab-dyyb), Infliximab, Kevzara (sarilumab), Kineret (anakinra), Leqselvi (deuruxolitinib), Litfulo (ritlicitinib), Nemludio (nemolizumab-ildo), Nucala (mepolizumab), Olumiant (baricitinib), Omlyclo (omalizumab-igec), Omvoh (mirikizumab-mrkz), Opzelura (ruxolitinib), Orencia (abatacept), Otezla (apremilast), Otezla XR (apremilast extended-release), Otulfi (ustekinumab-aauz), Pyzchiva (ustekinumab-ttwe), Remicade (infliximab), Renflexis (infliximab-abda), Rhapsido (remibrutinib), Riabni (rituximab-arrx), Rinvoq (upadacitinib), Rituxan (rituximab), Rituxan Hycela (rituximab/hyaluronidase human), Ruxience (rituximab-pvvr), Saphnelo (anifrolumab-fnia), Selarsdi (ustekinumab-aekn), Siliq (brodalumab), Simlandi (adalimumab-ryvk), Simponi (golimumab), Simponi ARIA (golimumab), Skyrizi (risankizumab-rzaa), Sotyktu (deucravacitinib), Spevigo (spesolimab-sbzo) subcutaneous injection, Starjemza (ustekinumab-hmny), Stelara (ustekinumab), Steqeyma (ustekinumab-stba), Taltz (ixekizumab), Tezspire (tezepelumab-ekko), Tofidence (tocilizumab-bavi), Tremfya (guselkumab), Truxima (rituximab-abbs), Tyenne (tocilizumab-aazg), Tyruko (natalizumab-sztn), Tysabri (natalizumab), Ustekinumab, Velsipity (etrasimod), Wezlana (ustekinumab-auub), Xeljanz (tofacitinib), Xeljanz XR (tofacitinib extended release), Xolair (omalizumab), Yesintek (ustekinumab-kfce), Yuflyma (adalimumab-aaty), Yusimry (adalimumab-aqvh), Zeposia (ozanimod), Zymfentra (infliximab-dyyb)]? Yes No
- If yes, does the prescribing information for the requested agent limit use with another immunomodulatory agent? Yes No
- If no, is there support for the use of combination therapy? **Please note, a submitted copy is required (i.e., clinical trials, phase III studies, guidelines)** Yes No

For prurigo nodularis (PN) requests:

8. Has the patient been diagnosed with stage four advanced, metastatic cancer and the requested agent is being used to treat the cancer? Yes No
9. Has the patient been diagnosed with stage four advanced, metastatic cancer and the requested agent is being used to treat an associated condition related to stage four advanced metastatic cancer? **Please note, chart notes are required.** Yes No
10. If yes to either of the previous two questions, is the use of the requested agent consistent with best practices for the treatment of stage four advanced, metastatic cancer, or an associated condition; supported by peer-reviewed, evidence-based literature; and approved by the United States Food and Drug Administration? Yes No
11. Does the patient have greater than or equal to 20 firm, nodular lesions? Yes No
12. Does the patient have pruritus that has lasted for at least 6 weeks? Yes No
13. Does the patient have history and/or signs of repeated scratching, picking, or rubbing? Yes No
14. Has the patient tried and had an inadequate response to ONE at least medium-potency topical corticosteroid used in the treatment of PN after at least a 2-week duration of therapy? Yes No
- If no, does the patient have an intolerance or hypersensitivity to therapy with ONE at least medium-potency topical corticosteroid used in the treatment of PN? Yes No
- If yes, please explain intolerance/hypersensitivity: _____
- If no, does the patient have an FDA labeled contraindication to ALL medium-, high-, and super-potency topical corticosteroids used in the treatment of PN? Yes No
- If yes, please specify contraindication: _____
15. Does the patient's medication history (excluding sample use) indicate use of a biologic immunomodulator agent or systemic targeted synthetic small molecule drug (e.g., oral JAK inhibitor) that is FDA labeled or supported in compendia (AHFS, DrugDex 1, 2a, or 2b level of evidence, or NCCN 1, 2a, or 2b recommended use) for the treatment of PN? Yes No
- If yes, please specify: _____

For Nemludio requests for prurigo nodularis (PN):

16. Is the request for an initial loading dose? Yes No
- If yes, does the requested quantity (dose) exceed the maximum FDA labeled dose for prurigo nodularis? Yes No
- If no, does the requested quantity (dose) exceed 60 mg every 4 weeks? Yes No

Please continue to the next page.

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
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For moderate-to-severe atopic dermatitis (AD) requests:

17. Does the patient have at least 10% body surface area involvement? Yes No
 If no, does the patient have involvement of body sites that are difficult to treat with prolonged topical corticosteroid therapy (e.g., hands, feet, face, neck, scalp, genitals/groin, skin folds)? Yes No
 If no, does the patient have an Eczema Area and Severity Index (EASI) score greater than or equal to 16? Yes No
 If no, does the patient have an Investigator Global Assessment (IGA) score of greater than or equal to 3? Yes No
18. Has the patient tried and had an inadequate response to ONE at least medium-potency topical corticosteroid used in the treatment of AD after at least a 4-week duration of therapy? Yes No
 If no, does the patient have an intolerance or hypersensitivity to ONE at least medium-potency topical corticosteroid used in the treatment of AD? Yes No
 If yes, please explain intolerance/hypersensitivity: _____

 If no, does the patient have an FDA labeled contraindication to ALL medium-, high- and super-potency topical corticosteroids used in the treatment of AD? Yes No
 If yes, please specify FDA labeled contraindication: _____

19. Has the patient tried and had an inadequate response to ONE topical calcineurin inhibitor (e.g., Elidel/pimecrolimus, Protopic/tacrolimus) used in the treatment of AD after at least a 6-week duration of therapy? Yes No
 If no, does the patient have an intolerance or hypersensitivity to ONE topical calcineurin inhibitor used in the treatment of AD? Yes No
 If yes, please explain intolerance/hypersensitivity: _____

 If no, does the patient have an FDA labeled contraindication to ALL topical calcineurin inhibitors used in the treatment of AD? Yes No
 If yes, please specify FDA labeled contraindication: _____

20. Does the patient's medication history (excluding sample use) indicate use of a biologic immunomodulator agent or systemic targeted synthetic small molecule drug (e.g., oral JAK inhibitor) that is FDA labeled or supported in compendia (AHFS, DrugDex 1, 2a, or 2b level of evidence, or NCCN 1, 2a, or 2b recommended use) for the treatment of AD? Yes No
 If yes, please specify: _____
21. Is the patient currently treated with topical emollients and practicing good skin care? Yes No
 If yes, will the patient continue the use of topical emollients and good skin care practices in combination with the requested agent? Yes No
22. Is the patient initiating therapy with the requested agent? Yes No
 If no, has the patient been treated with the requested agent for less than 16 consecutive weeks? Yes No
 If no, is the requested dose 30 mg every 8 weeks? Yes No
 If no, is the requested dose 30 mg every 4 weeks? Yes No
 If yes, has the patient achieved clear or almost clear skin? Yes No
 If no, please provide support for continued therapy at the requested dose of 30 mg every 4 weeks: _____

Please continue to the next page.

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
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For renewal requests:

23. Has the patient had clinical benefit with the requested agent? Yes No

For moderate-to-severe atopic dermatitis (AD) renewal requests:

24. Will the patient continue standard maintenance therapies (e.g., topical emollients, good skin care practices) in combination with the requested agent? Yes No

25. Will the patient continue topical corticosteroid OR topical calcineurin inhibitor therapy in combination with the requested agent? Yes No

If no, has the patient been treated with the requested agent for at least 16 consecutive weeks? Yes No

If yes, has the patient's atopic dermatitis sufficiently improved?..... Yes No

26. Based on disease activity, have concurrent topical therapies (e.g., topical corticosteroid, topical calcineurin inhibitor) been tapered and discontinued? Yes No

27. Does the patient have an intolerance, hypersensitivity, or FDA labeled contraindication to ALL topical corticosteroids AND topical calcineurin inhibitors? Yes No

If yes, please explain: _____

Please fax or mail this form to:
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TOLL FREE

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