Louisiana Medicaid
Nemolizumab-ilto (Nemluvio®)

The *Louisiana Uniform Prescription Drug Prior Authorization Form* should be utilized to request clinical authorization for nemolizumab-ilto (Nemluvio®).

Additional Point-of-Sale edits may apply.

By submitting the authorization request, the prescriber attests to the conditions available HERE.

Approval Criteria for Initiation of Therapy for Prurigo Nodularis

- The recipient is 18 years of age or older on the date of the request; **AND**
- The recipient has a diagnosis of prurigo nodularis (PN); **AND**
- The medication is prescribed by, or the request states that this medication is being prescribed in consultation with, a dermatologist, immunologist, or allergist; **AND**
- **ONE** of the following:
    - There has been a treatment failure or intolerable side effect with a preferred super-potent topical corticosteroid agent (see Dermatology – Steroids, Topical – High and Very High Potency); **OR**
    - The recipient has a contraindication to **ALL** preferred super-potent topical corticosteroid agents (see Dermatology – Steroids, Topical – High and Very High Potency); **AND**
- The prescriber **states on the request** that the medication requested is not prescribed concurrently with another biologic immunomodulator or JAK inhibitor; **AND**
- If request is for a non-preferred agent - **ONE** of the following is required: (see Dermatology – Atopic Dermatitis Immunomodulators on the PDL/NPDL for a list of preferred agents)
    - The recipient has had a *treatment failure* with at least one preferred product; **OR**
    - The recipient has had an *intolerable side effect* to at least one preferred product; **OR**
    - The recipient has *documented contraindication(s)* to all of the preferred products that are appropriate to use for the condition being treated; **OR**
    - There is *no preferred product that is appropriate* to use for the condition being treated.

Approval Criteria for Continuation of Therapy for Prurigo Nodularis

- The prescriber **states on the request** that there is evidence of a positive response to therapy including a significant reduction in areas affected and/or severity of PN; **AND**
- The prescriber **states on the request** that the medication requested is not prescribed concurrently with another biologic immunomodulator or JAK inhibitor.

Approval Criteria for Initiation of Therapy for Atopic Dermatitis

- The recipient is 12 years of age or older on the date of the request; **AND**

- The recipient has a diagnosis of moderate to severe atopic dermatitis (AD); **AND**
- The medication is prescribed by, or the request states that this medication is being prescribed in consultation with, a dermatologist, immunologist, or allergist; **AND**
- **ONE** of the following:
    - There has been a treatment failure or intolerable side effect with a preferred topical corticosteroid agent (see Dermatology – Steroids, Topical – High and Very High Potency) or a preferred topical calcineurin inhibitor (see Dermatology – Atopic Dermatitis Immunomodulators); **OR**
    - The recipient has a contraindication to **ALL** topical corticosteroid agents (see Dermatology – Steroids, Topical – High and Very High Potency) and topical calcineurin inhibitors (see Dermatology – Atopic Dermatitis Immunomodulators); **AND**
- The requested medication is prescribed concurrently with a topical corticosteroid and/or topical calcineurin inhibitor, unless contraindicated or clinically significant adverse effects are experienced; **AND**
- The prescriber **states on the request** that the medication requested is not prescribed concurrently with another biologic immunomodulator or JAK inhibitor; **AND**
- If request is for a non-preferred agent - **ONE** of the following is required: (see Dermatology – Atopic Dermatitis Immunomodulators on the PDL/NPDL for a list of preferred agents)
    - The recipient has had a *treatment failure* with at least one preferred product; **OR**
    - The recipient has had an *intolerable side effect* to at least one preferred product; **OR**
    - The recipient has *documented contraindication(s)* to all of the preferred products that are appropriate to use for the condition being treated; **OR**
    - There is *no preferred product that is appropriate* to use for the condition being treated.

Approval Criteria for Continuation of Therapy for Atopic Dermatitis

- The prescriber **states on the request** that there is evidence of a positive response to therapy including a significant reduction in areas affected and/or severity of AD; **AND**
- The prescriber **states on the request** that the medication requested is not prescribed concurrently with another biologic immunomodulator or JAK inhibitor.

Duration of approval for initiation of therapy: 6 months
Duration of approval for continuation of therapy: 12 months

References

Nemluvio (nemolizumab-ilto) [package insert]. Dallas, TX: Galderma Laboratories; December 2024. https://www.galderma.com/sites/default/files/2024-12/Nemluvio_Dual%20PI%20for%20website%2013Dec24.pdf

Satoh T, Yokozeki H, Murota H, et al. 2020 Guidelines for the Diagnosis and Treatment of Prurigo. *J Dermatol*. 2021;48(9):e414-e431. doi:10.1111/1346-8138.16067

Revision / Date	**Implementation Date**
Policy created / November 2024	March 2025