UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

Program Number	2025 P 1478-1
Program	Prior Authorization/Notification
Medications	Nemluvio® (nemolizumab-ilto)
P&T Approval Date	6/2025
Effective Date	9/1/2025

1. Background:

Nemluvio (nemolizumab-ilto) is an interleukin-31 receptor antagonist indicated for the treatment of adults with prurigo nodularis and for the treatment of adults and pediatric patients 12 years of age and older with moderate to severe atopic dermatitis in combination with topical corticosteroids and/or calcineurin inhibitors when the disease is not adequately controlled with topical prescription therapies.

2. Coverage Criteria[a]:

A. Atopic Dermatitis

1. **Initial Authorization**

a. **Nemluvio** will be approved based on **all** of the following criteria:

(1) Diagnosis of moderate to severe atopic dermatitis

-AND-

(2) Will be used in combination with topical corticosteroids and/or calcineurin inhibitors when the disease is not adequately controlled with topical prescription therapies

-AND-

(3) Patient is not receiving Nemluvio in combination with **either** of the following for treatment of the same indication:

(a) Biologic immunomodulator [e.g., Adbry (tralokinumab-ldrm), Dupixent (dupilumab), Ebglyss (lebrikizumab-lbkz)]
(b) Janus kinase inhibitor [e.g., Rinvoq (upadacitinib), Xeljanz/XR (tofacitinib), Opzelura (topical ruxolitinib), Cibinqo (abrocitinib)]

Authorization will be issued for 12 months.

2. **Reauthorization**

a. **Nemluvio** will be approved based on **both** of the following criteria:

(1) Documentation of positive clinical response to Nemluvio therapy

-AND-

(2) Patient is not receiving Nemluvio in combination with **either** of the following for treatment of the same indication:

(a) Biologic immunomodulator [e.g., Adbry (tralokinumab-ldrm), Dupixent (dupilumab), Ebglyss (lebrikizumab-lbkz)]
(b) Janus kinase inhibitor [e.g., Rinvoq (upadacitinib), Xeljanz/XR (tofacitinib), Opzelura (topical ruxolitinib), Cibinqo (abrocitinib)]

Authorization will be issued for 12 months.

B. Prurigo Nodularis

1. **Initial Authorization**

a. **Nemluvio** will be approved based on **both** of the following criteria:

(1) Diagnosis of prurigo nodularis

-AND-

(2) Patient is not receiving Nemluvio in combination with Dupixent for treatment of the same indication

Authorization will be issued for 12 months.

2. **Reauthorization**

a. **Nemluvio** will be approved based on **both** of the following criteria:

(1) Documentation of positive clinical response to Nemluvio therapy

-AND-

(2) Patient is not receiving Nemluvio in combination with Dupixent for treatment of the same indication

Authorization will be issued for 12 months.

[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3. Additional Clinical Programs:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10)

and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limitations may be in place.
- Medical Necessity may be in place.

4. References:

1. Nemluvio [package insert]. Dallas, TX: Galderma Laboratories, L.P., December 2024.

Program	Prior Authorization/Notification - Nemluvio (nemolizumab-ilto)
Change Control	
6/2025	New program.