PRIOR AUTHORIZATION REQUEST

Skyrizi IV-Subq/On-Body

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll-free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please note that supporting clinical documentation is required for **ALL** PA requests. Pharmacy prior authorization reviews can be subject to trial with additional medications that are not listed within the criteria. The policies are subject to change based on COMAR requirements, MDH transmittals and updates to treatment guidelines.

1	Will the requested medication be used in combination with a biologic disease-modifying antirheumatic drug (DMARD) or targeted synthetic DMARD? [Note: Examples of biologics include but not limited to adalimumab SC products (for example, Humira, biosimilars), Actemra (IV or SC), Cimzia, Cosentyx, an etanercept SC product (for example, Enbrel, biosimilars), Ilumya, Skyrizi, Kevzara, Kineret, Orencia (IV or SC), an infliximab IV product (for example, Remicade, biosimilars), a rituximab IV product (for example, Rituxan, biosimilars), Siliq, Stelara (IV or SC), Taltz, Tremfya, Entyvio, or Simponi (Aria or SC). Examples of targeted synthetic DMARD include but not limited to Cibinqo, Olumiant, Rinvoq,	Yes	No

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	Otezla, Xeljanz, Xeljanz XR.] [If yes, no further questions.]		
2	What is the requested medication? [] Skyrizi INTRAVENOUS (If checked, go to 25) [] Skyrizi SUBCUTANEOUS, Skyrizi on-body SUBCUTANEOUS (If checked, go to 3)		
3	Is the patient currently receiving the requested medication? [If no, skip to question 24.]	Yes	No
4	Has the patient been receiving medication samples for the requested medication? [If yes, skip to question 24.]	Yes	No
5	Does the patient have a previously approved prior authorization (PA) on file with the current plan? [Note: If the patient does NOT have a previously approved PA on file for the requested medication with the current plan, the renewal request will be considered under initial therapy.] [If no, skip to question 15.]	Yes	No
6	What is the indication or diagnosis? [] Psoriatic Arthritis (If checked, go to 48) [] Plaque Psoriasis (If checked, go to 38) [] Crohn's Disease (If checked, go to 7) [] Ulcerative Colitis (If checked, go to 11) [] Other (If checked, no further questions)		
7	Has the patient been on established therapy for at least 3 months? [If no, skip to question 27.]	Yes	No
8	Does the provider attest that the patient is not requesting Skyrizi IV infusions for maintenance therapy? [If no, no further questions.]	Yes	No
9	Has the patient experienced a beneficial clinical response from baseline (prior to initiating the requested medication)? [Note: Examples of objective measures include fecal markers (such as, fecal lactoferrin, fecal calprotectin), serum markers (such as, C-reactive protein), imaging studies (magnetic resonance enterography, computed tomography enterography), endoscopic assessment, and/or reduced dose of corticosteroids.] [If yes, no further questions.]	Yes	No

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10	Compared with baseline (prior to initiating the requested medication), has the patient experienced an improvement in at least ONE symptom, such as decreased pain, fatigue, stool frequency, and/or blood in stool? [No further questions.]	Yes	No
11	Has the patient been on established therapy for at least 3 months? [If no, skip to question 60.]	Yes	No
12	Does the provider attest that the patient is not requesting Skyrizi IV infusions for maintenance therapy? [If no, no further questions.]	Yes	No
13	Has the patient experienced a beneficial clinical response from baseline (prior to initiating the requested medication)? [Note: Examples of objective measures include fecal markers (such as, fecal lactoferrin, fecal calprotectin), serum markers (such as, C-reactive protein), imaging studies (magnetic resonance enterography, computed tomography enterography), endoscopic assessment, and/or reduced dose of corticosteroids.] [If yes, no further questions.]	Yes	No
14	Compared with baseline (prior to initiating the requested medication), has the patient experienced an improvement in at least ONE symptom, such as decreased pain, fatigue, stool frequency, and/or blood in stool? [No further questions.]	Yes	No
15	What is the indication or diagnosis? [] Psoriatic Arthritis (If checked, go to 20) [] Plaque Psoriasis (If checked, go to 18) [] Crohn's Disease (If checked, go to 16) [] Ulcerative Colitis (If checked, go to 22) [] Other (If checked, no further questions)		
16	Has the patient experienced a beneficial clinical response from baseline (prior to initiating the requested medication)? [Note: Examples of objective measures include fecal markers (such as, fecal lactoferrin, fecal calprotectin), serum markers (such as, C-reactive protein), imaging studies (magnetic resonance enterography, computed tomography enterography), endoscopic assessment, and/or reduced dose of corticosteroids.] [If yes, skip to question 27.]	Yes	No
17	Compared with baseline (prior to initiating the requested medication), has the patient experienced an improvement in at least ONE symptom, such as decreased pain, fatigue, stool frequency, and/or blood in stool? [If yes, skip to question 27.]	Yes	No

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	[If no, no further questions.]		
18	Has the patient experienced a beneficial clinical response from baseline (prior to initiating the requested medication) in at least ONE of the following: A) Estimated body surface area, B) Erythema, C) Induration/thickness, and/or D) Scale of areas affected by psoriasis? [If no, no further questions.]	Yes	No
19	Compared with baseline (prior to initiating the requested medication), has the patient experienced an improvement in at least ONE symptom, such as decreased pain, itching, and/or burning? [If yes, skip to question 41.] [If no, no further questions.]	Yes	No
20	Has the patient experienced a beneficial clinical response from baseline (prior to initiating the requested medication) in at least ONE objective measure? [Note: Examples of objective measures of disease activity include Disease Activity Index for Psoriatic Arthritis (DAPSA), Composite Psoriatic Disease Activity Index (CPDAI), Psoriatic Arthritis Disease Activity Score (PsA DAS), Grace Index, Leeds Enthesitis Score (LEI), Spondyloarthritis Consortium of Canada (SPARCC) enthesitis score, Leeds Dactylitis Instrument Score, Minimal Disease Activity (MDA), Psoriatic Arthritis Impact of Disease (PsAID-12), and/or serum markers (such as, C-reactive protein, erythrocyte sedimentation rate).] [If yes, skip to question 51.]	Yes	No
21	Compared with baseline (prior to initiating the requested medication), has the patient experienced an improvement in at least ONE symptom, such as less joint pain, morning stiffness, or fatigue; improved function or activities of daily living; or decreased soft tissue swelling in joints or tendon sheaths? [If yes, skip to question 51.] [If no, no further questions.]	Yes	No
22	Has the patient experienced a beneficial clinical response from baseline (prior to initiating the requested medication)? [Note: Examples of objective measures include fecal markers (such as, fecal lactoferrin, fecal calprotectin), serum markers (such as, C-reactive protein), imaging studies (magnetic resonance enterography, computed tomography enterography), endoscopic assessment, and/or reduced dose of corticosteroids.] [If yes, skip to question 60.]	Yes	No
23	Compared with baseline (prior to initiating the requested medication), has the patient experienced an improvement in at least ONE symptom, such as decreased pain, fatigue, stool frequency, and/or blood in stool? [If yes, skip to question 60.] [If no, no further questions.]	Yes	No
24	What is the indication or diagnosis? [] Psoriatic Arthritis (If checked, go to 51)		

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[] Plaque Psoriasis (If checked, go to 41)

[] Crohn's Disease (If checked, no further questions)

[] Ulcerative Colitis (If checked, no further questions)

[] Other (If checked, no further questions)

25 What is the indication or diagnosis?
[] Crohn's Disease (If checked, go to 26)

[] Ulcerative Colitis (If checked, go to 59)

[] Other (If checked, no further questions)

26	Does the provider attest that the loading dose phase will be limited to 3 IV infusions (600 mg each) and 1 subcutaneous injection? [If no, no further questions.]	Yes	No
27	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No
28	Has the patient tried or is the patient currently taking corticosteroids? [Note: Examples of corticosteroids are prednisone or methylprednisolone.] [If yes, skip to question 33.]	Yes	No
29	Does the patient have a contraindication to corticosteroids? [Note: Examples of corticosteroids are prednisone or methylprednisolone.] [If yes, skip to question 33.]	Yes	No
30	Has the patient tried TWO other conventional systemic therapies for Crohn's disease for at least 3 months? [Note: Examples of conventional systemic therapy for Crohn's disease include azathioprine, 6-mercaptopurine, or methotrexate.] [If yes, skip to question 33.]	Yes	No
31	Does the patient have enterocutaneous (perianal or abdominal) or rectovaginal fistulas? [If yes, skip to question 33.]	Yes	No
32	Has the patient had an ileocolonic resection (to reduce the chance of Crohn's disease recurrence)? [If no, no further questions.]	Yes	No
33	Has documentation been submitted to confirm that the patient has had an intolerance, contraindication to, or failed treatment for at least 3 months with preferred TNF inhibitor an adalimumab product (Hadlima, Simlandi, Yusimry, or	Yes	No

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	adalimumab-adbm)? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]		
34	Has documentation been submitted to confirm that the patient has had a treatment failure with a preferred ustekinumab product (Yesintek, Pyzchiva, Steqeyma), for at least 3 months or is the patient intolerant or the medication contraindicated? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
35	Does the requested dose exceed the FDA approved label dosing for the indication? (Dosing: Induction: IV: 600 mg at weeks 0, 4, and 8. Dosing: Maintenance: SC: 180 to 360 mg at week 12 and every 8 weeks thereafter.) [If yes, no further questions.]	Yes	No
36	According to the prescriber, will the patient receive induction dosing with Skyrizi intravenous within 3 months of initiating therapy with Skyrizi subcutaneous? [If no, no further questions.]	Yes	No
37	Is the requested medication being prescribed by or in consultation with a gastroenterologist? [No further questions.]	Yes	No
38	Has the patient been on established therapy for at least 3 months? [If no, skip to question 41.]	Yes	No
39	Has the patient experienced a beneficial clinical response from baseline (prior to initiating the requested medication) in at least ONE of the following: A) Estimated body surface area, B) Erythema, C) Induration/thickness, and/or D) Scale of areas affected by psoriasis? [If no, no further questions.]	Yes	No
40	Compared with baseline (prior to initiating the requested medication), has the patient experienced an improvement in at least ONE symptom, such as decreased pain, itching, and/or burning? [No further questions.]	Yes	No
41	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No
42	Has the patient tried at least TWO traditional systemic agents for psoriasis for at least 3 months? [Note: Examples of traditional systemic agents for psoriasis include methotrexate, cyclosporine, or acitretin tablets.] [If yes, skip to question 44.]	Yes	No
43	Has documentation been submitted to confirm that the patient has an intolerance to at least TWO traditional systemic agents for psoriasis? ACTION REQUIRED: Submit supporting documentation.	Yes	No

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	[Note: Examples of traditional systemic agents for psoriasis include methotrexate, cyclosporine, or acitretin tablets.] [If no, no further questions.]		
44	Has documentation been submitted to confirm that the patient has had a treatment failure with preferred TNF inhibitors, Enbrel (etanercept) and an adalimumab product (Hadlima, Simlandi, Yusimry, or adalimumab-adbm) for at least 3 months unless intolerant or contraindicated? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
45	Has documentation been submitted to confirm that the patient has had a treatment failure with a preferred ustekinumab product (Yesintek, Pychiva, Steqeyma), for at least 3 months or is the patient intolerant or the medication contraindicated? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
46	Does the requested dose exceed the FDA approved label dosing for the indication? (Dosing: 150 mg at weeks 0, 4, and then every 12 weeks thereafter) [If yes, no further questions.]	Yes	No
47	Is the requested medication being prescribed by or in consultation with a dermatologist? [No further questions.]	Yes	No
48	Has the patient been on established therapy for at least 3 months? [If no, skip to question 51.]	Yes	No
49	Has the patient experienced a beneficial clinical response from baseline (prior to initiating the requested medication) in at least ONE objective measure? [Note: Examples of objective measures of disease activity include Disease Activity Index for Psoriatic Arthritis (DAPSA), Composite Psoriatic Disease Activity Index (CPDAI), Psoriatic Arthritis Disease Activity Score (PsA DAS), Grace Index, Leeds Enthesitis Score (LEI), Spondyloarthritis Consortium of Canada (SPARCC) enthesitis score, Leeds Dactylitis Instrument Score, Minimal Disease Activity (MDA), Psoriatic Arthritis Impact of Disease (PsAID-12), and/or serum markers (such as, C-reactive protein, erythrocyte sedimentation rate).] [If yes, no further questions.]	Yes	No
50	Compared with baseline (prior to initiating the requested medication), has the patient experienced an improvement in at least ONE symptom, such as less joint pain, morning stiffness, or fatigue; improved function or activities of daily living; or decreased soft tissue swelling in joints or tendon sheaths? [No further questions.]	Yes	No
51	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No

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52	Has the patient tried TWO conventional synthetic disease-modifying antirheumatic drug (DMARD) for at least 3 months? [Note: Examples of conventional synthetic DMARDs include methotrexate (oral or injectable), leflunomide, hydroxychloroquine, and sulfasalazine.] [If yes, skip to question 54.]	Yes	No
53	Has documentation been submitted to confirm that the patient has an intolerance to at least TWO conventional synthetic DMARDs? ACTION REQUIRED: Submit supporting documentation. [Note: Examples of conventional synthetic DMARDs include methotrexate (oral or injectable), leflunomide, hydroxychloroquine, and sulfasalazine.] [If no, no further questions.]	Yes	No
54	Has documentation been submitted to confirm that the patient has had a treatment failure with preferred TNF inhibitors, Enbrel (etanercept) and an adalimumab product (Hadlima, Simlandi, Yusimry, or adalimumab-adbm) for at least 3 months unless intolerant or contraindicated? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
55	Has documentation been submitted to confirm that the patient has had a treatment failure with a preferred ustekinumab product (Yesintek, Pyzchiva, Steqeyma), for at least 3 months or is the patient intolerant or the medication contraindicated? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
56	Has documentation been submitted to confirm that the patient has had a treatment failure with Xeljanz (tofacitinib) for at least 3 months unless intolerant or contraindicated? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
57	Does the requested dose exceed the FDA approved label dosing for the indication? (Dosing: 150 mg at weeks 0, 4, and then every 12 weeks thereafter) [If yes, no further questions.]	Yes	No
58	Is the requested medication being prescribed by or in consultation with a rheumatologist or a dermatologist? [No further questions.]	Yes	No
59	Does the provider attest that the loading dose phase will be limited to 3 IV infusions (1200 mg each) and 1 subcutaneous injection? [If no, no further questions.]	Yes	No
60	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No
61	Has the patient tried or is the patient currently taking corticosteroids? [Note: Examples of corticosteroids are prednisone or methylprednisolone.]	Yes	No

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	[If yes, skip to question 63.]		
62	Does the patient have a contraindication to corticosteroids? [Note: Examples of corticosteroids are prednisone or methylprednisolone.] [If no, no further questions.]	Yes	No
63	Has the patient tried TWO other conventional systemic therapies for Ulcerative Colitis for at least 3 months? [Note: Examples of conventional systemic therapy for Ulcerative Colitis include azathioprine, 6-mercaptopurine, or methotrexate.] [If no, no further questions.]	Yes	No
64	Has documentation been submitted to confirm that the patient has had an intolerance, contraindication to, or failed treatment for at least 3 months with preferred TNF inhibitor an adalimumab product (Hadlima, Simlandi, Yusimry, or adalimumab-adbm)? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
65	Has documentation been submitted to confirm that the patient has had a treatment failure with Xeljanz (tofacitinib) for at least 3 months unless intolerant or contraindicated? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
66	Has documentation been submitted to confirm that the patient has had a treatment failure with a preferred ustekinumab product (Yesintek, Pyzchiva, Steqeyma), for at least 3 months or is the patient intolerant or the medication contraindicated? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
67	Does the requested dose exceed the FDA approved label dosing for the indication? (Dosing: Induction: IV: 1,200 mg at weeks 0, 4, and 8. Dosing: Maintenance: SC: 180 to 360 mg at week 12 and every 8 weeks thereafter.) [If yes, no further questions.]	Yes	No
68	According to the prescriber, will the patient receive induction dosing with Skyrizi intravenous within 3 months of initiating therapy with Skyrizi subcutaneous? [If no, no further questions.]	Yes	No
69	Is the requested medication being prescribed by or in consultation with a gastroenterologist?	Yes	No

Please document the diagnoses, symptoms, and/or any other information important to this review:

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SECTION B: Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 1-833-896-0656

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

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