PRIOR AUTHORIZATION REQUEST

SKYRIZI

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	Is this request for initial therapy or for a continuation of therapy? [] Initial (If checked, go to 8) [] Continuation (If checked, go to 2)		
2	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	Yes	No

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	(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, Otezla, Xeljanz, Xeljanz XR.] [If yes, no further questions.]		
3	Is the patient currently receiving the requested medication? [If no, skip to question 8.]	Yes	No
4	Has the patient been receiving medication samples for the requested medication? [If yes, skip to question 8.]	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 8.]	Yes	No
6	Has the patient been established on therapy for at least 3 months? [If no, skip to question 8.]	Yes	No
7	Has documentation been submitted to confirm that the patient has experienced a significant response to therapy, as determined by the provider? ACTION REQUIRED: Submit supporting documentation. [No further questions.]	Yes	No
8	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, Otezla, Xeljanz, Xeljanz XR.] [If yes, no further questions.]	Yes	No
9	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No
10	What is the requested medication? [] Skyrizi INTRAVENOUS (If checked, go to 12)		

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[] Skyrizi SUBCUTANEOUS, Skyrizi on-body SUBCUTANEOUS (If checked, go to 11)

11 What is the indication or diagnosis?

[] Psoriatic Arthritis (If checked, go to 31)

[] Plaque Psoriasis (If checked, go to 25)

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

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

[] Other (If checked, no further questions)

12 Will the requested medication be used as induction therapy? Yes No
[If no, no further questions.]

13 What is the indication or diagnosis?

[] Crohn's Disease (If checked, go to 14)

[] Ulcerative Colitis (If checked, go to 38)

[] Plaque Psoriasis (If checked, no further questions)

[] Psoriatic Arthritis (If checked, no further questions)

[] Other (If checked, no further questions)

14 Does the provider attest that the loading dose phase will be limited to 3 intravenous (IV) infusions (600 mg each) and 1 subcutaneous (SC) injection? Yes No
[If no, no further questions.]

15 Has the patient tried or is the patient currently taking corticosteroids? Yes No
[Note: Examples of corticosteroids are prednisone or methylprednisolone.]
[If yes, skip to question 20.]

16 Does the patient have a contraindication to corticosteroids? Yes No
[Note: Examples of corticosteroids are prednisone or methylprednisolone.]
[If yes, skip to question 20.]

17 Has the patient tried TWO other conventional systemic therapies for Crohn's disease for at least 3 months? Yes No
[Note: Examples of conventional systemic therapy for Crohn's disease include azathioprine, 6-mercaptopurine, or methotrexate.]
[If yes, skip to question 20.]

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18	Does the patient have enterocutaneous (perianal or abdominal) or rectovaginal fistulas? [If yes, skip to question 20.]	Yes	No
19	Has the patient had an ileocolonic resection (to reduce the chance of Crohn's disease recurrence)? [If no, no further questions.]	Yes	No
20	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 tumor necrosis factor (TNF) inhibitor or an adalimumab product (Hadlima, Simlandi, Yusimry, or adalimumab-adbm)? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
21	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
22	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
23	Is the requested medication being prescribed by or in consultation with a gastroenterologist? [If no, no further questions.]	Yes	No
24	Does the requested dose exceed the Food and Drug Administration (FDA) approved label dosing for the indication? [Note: Induction dosing: 600 mg IV at weeks 0, 4, and 8. Maintenance dosing: 180 to 360 mg SC at week 12 and every 8 weeks thereafter.] [No further questions.]	Yes	No
25	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 27.]	Yes	No
26	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. [Note: Examples of traditional systemic agents for psoriasis include methotrexate, cyclosporine, or acitretin tablets.] [If no, no further questions.]	Yes	No

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27	Has documentation been submitted to confirm that the patient has had a treatment failure with a preferred 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
28	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
29	Is the requested medication being prescribed by or in consultation with a dermatologist? [If no, no further questions.]	Yes	No
30	Does the requested dose exceed the Food and Drug Administration (FDA) approved label dosing for the indication? [Note: Dosing: 150 mg at weeks 0, 4, and then every 12 weeks thereafter.] [No further questions.]	Yes	No
31	Has the patient tried TWO conventional synthetic disease-modifying antirheumatic drugs (DMARDs) 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 33.]	Yes	No
32	Has documentation been submitted to confirm that the patient has an intolerance to at least TWO conventional synthetic disease-modifying antirheumatic drugs (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
33	Has documentation been submitted to confirm that the patient has had a treatment failure with a preferred 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
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	Has documentation been submitted to confirm that the patient has had a treatment	Yes	No

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	failure with Xeljanz (tofacitinib) for at least 3 months unless intolerant or contraindicated? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]		
36	Is the requested medication being prescribed by or in consultation with a rheumatologist or a dermatologist? [If no, no further questions.]	Yes	No
37	Does the requested dose exceed the Food and Drug Administration (FDA) approved label dosing for the indication? [Note: Dosing: 150 mg at weeks 0, 4, and then every 12 weeks thereafter.] [No further questions.]	Yes	No
38	Does the provider attest that the loading dose phase will be limited to 3 intravenous (IV) infusions (1200 mg each) and 1 subcutaneous (SC) injection? [If no, no further questions.]	Yes	No
39	Has the patient tried or is the patient currently taking corticosteroids? [Note: Examples of corticosteroids are prednisone or methylprednisolone.] [If yes, skip to question 41.]	Yes	No
40	Does the patient have a contraindication to corticosteroids? [Note: Examples of corticosteroids are prednisone or methylprednisolone.] [If no, no further questions.]	Yes	No
41	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
42	Has documentation been submitted to confirm that the patient has had an intolerance, contraindication to, or failed treatment for at least 3 months with a preferred adalimumab product (Hadlima, Simlandi, Yusimry, or adalimumab-adbm)? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
43	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
44	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

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45	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
46	Is the requested medication being prescribed by or in consultation with a gastroenterologist? [If no, no further questions.]	Yes	No
47	Does the requested dose exceed the Food and Drug Administration (FDA) approved label dosing for the indication? [Note: Induction dosing: 1,200 mg IV at weeks 0, 4, and 8. Maintenance dosing: 180 to 360 mg SC at week 12 and every 8 weeks thereafter.]	Yes	No

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

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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