



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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Version 07.2026

PRIOR AUTHORIZATION REQUEST

(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.]

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| 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 | What is the requested medication?

☐ Skyrizi INTRAVENOUS (If checked, go to 11)

☐ Skyrizi SUBCUTANEOUS, Skyrizi on-body SUBCUTANEOUS (If checked, go to 10) | | |

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Version 07.2026

PRIOR AUTHORIZATION REQUEST

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|----|--|-----|----|
| 10 | <p>What is the indication or diagnosis?</p> <p>☐ Psoriatic Arthritis (If checked, go to 31)</p> <p>☐ Plaque Psoriasis (If checked, go to 24)</p> <p>☐ Crohn's Disease (If checked, no further questions)</p> <p>☐ Ulcerative Colitis (If checked, no further questions)</p> <p>☐ Other (If checked, no further questions)</p> | | |
| 11 | <p>What is the indication or diagnosis?</p> <p>☐ Crohn's Disease (If checked, go to 12)</p> <p>☐ Ulcerative Colitis (If checked, go to 39)</p> <p>☐ Plaque Psoriasis (If checked, no further questions)</p> <p>☐ Psoriatic Arthritis (If checked, no further questions)</p> <p>☐ Other (If checked, no further questions)</p> | | |
| 12 | <p>Is the patient greater than or equal to 18 years of age?</p> <p>[If no, no further questions.]</p> | Yes | No |
| 13 | <p>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?</p> <p>[If no, no further questions.]</p> | Yes | No |
| 14 | <p>Has the patient tried or is the patient currently taking corticosteroids?</p> <p>[Note: Examples of corticosteroids are prednisone or methylprednisolone.]</p> <p>[If yes, skip to question 19.]</p> | Yes | No |
| 15 | <p>Does the patient have a contraindication to corticosteroids?</p> <p>[Note: Examples of corticosteroids are prednisone or methylprednisolone.]</p> <p>[If yes, skip to question 19.]</p> | Yes | No |
| 16 | <p>Has the patient tried TWO other conventional systemic therapies for Crohn's disease for at least 3 months?</p> <p>[Note: Examples of conventional systemic therapy for Crohn's disease include azathioprine, 6-mercaptopurine, or methotrexate.]</p> <p>[If yes, skip to question 19.]</p> | Yes | No |
| 17 | <p>Does the patient have enterocutaneous (perianal or abdominal) or rectovaginal fistulas?</p> | Yes | No |

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Version 07.2026

PRIOR AUTHORIZATION REQUEST

[If yes, skip to question 19.]

18	Has the patient had an ileocolonic resection (to reduce the chance of Crohn's disease recurrence)? [If no, no further questions.]	Yes	No
19	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
20	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
21	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
22	Is the requested medication being prescribed by or in consultation with a gastroenterologist? [If no, no further questions.]	Yes	No
23	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
24	Is the patient greater than or equal to 6 years of age? [If no, 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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Version 07.2026

PRIOR AUTHORIZATION REQUEST

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	Is the patient greater than or equal to 6 years of age? [If no, no further questions.]	Yes	No
32	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 34.]	Yes	No
33	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
34	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
35	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.	Yes	No

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Version 07.2026

PRIOR AUTHORIZATION REQUEST

[If no, no further questions.]

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|----|---|-----|----|
| 36 | 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 |
| 37 | Is the requested medication being prescribed by or in consultation with a rheumatologist or a dermatologist?
[If no, no further questions.] | Yes | No |
| 38 | 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 |
| 39 | Is the patient greater than or equal to 18 years of age?
[If no, no further questions.] | Yes | No |
| 40 | 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 |
| 41 | Has the patient tried or is the patient currently taking corticosteroids?
[Note: Examples of corticosteroids are prednisone or methylprednisolone.]
[If yes, skip to question 43.] | Yes | No |
| 42 | Does the patient have a contraindication to corticosteroids?
[Note: Examples of corticosteroids are prednisone or methylprednisolone.]
[If no, no further questions.] | Yes | No |
| 43 | 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 |
| 44 | Has the patient been diagnosed with moderate to severe Ulcerative Colitis?
[If no, skip to question 47.] | Yes | No |
| 45 | Has documentation been submitted to confirm that the patient has moderate to severe symptoms? ACTION REQUIRED: Submit supporting documentation.
[Note: Examples include Mayo endoscopy sub-score greater than or equal to 2, greater than 6 bowel movements per day, greater than or equal to 4 bloody stools per day, hemoglobin less than 75% normal (males less than 10 g/dL, females less than 9 g/dL).]
[If yes, skip to question 50.] | Yes | No |

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Version 07.2026

PRIOR AUTHORIZATION REQUEST

46	Has documentation been submitted to confirm that the patient has mildly active symptoms with poor prognosis factors for disease severity? ACTION REQUIRED: Submit supporting documentation. [Note: Examples include Mayo endoscopy sub-score equal to 3, extensive colitis, corticosteroid dependence (unable to taper after 3 months of continuous therapy), elevated CRP greater than or equal to 10 mg/dL, low serum albumin less than 3.4 mg/dL.] [If yes, skip to question 50.]	Yes	No
47	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
48	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
49	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 yes, skip to question 52.] [If no, no further questions.]	Yes	No
50	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 Infliximab product? ACTION REQUIRED: Submit supporting documentation. [Note: Infusion dates and dosages are required.] [If no, no further questions.]	Yes	No
51	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
52	Is the requested medication being prescribed by or in consultation with a gastroenterologist? [If no, no further questions.]	Yes	No
53	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



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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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