# Skyrizi (risankizumab-rzaa)
## Prior Authorization Request Form

Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

**MEMBER'S LAST NAME:** ______________________________ **MEMBER'S FIRST NAME:** ______________________________

**Instructions:** Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

☐ **URGENT**

| MEMBER INFORMATION | |
|---|---|
| **LAST NAME:** | **FIRST NAME:** |
| **PHONE NUMBER:** | **DATE OF BIRTH:** |
| **STREET ADDRESS:** | |
| **CITY:** | **STATE:** **ZIP CODE:** |
| **PATIENT INSURANCE ID NUMBER:** | |

☐ **MALE** ☐ **FEMALE** **HEIGHT (IN/CM):** ______ **WEIGHT (LB/KG):** ______ **ALLERGIES:** ______________________

**IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK:** HTTPS://MAGELLANRX.COM/MEMBER/EXTERNAL/COMMERCIAL/COMMON/DOC/EN-US/PHI_DISCLOSURE_AUTHORIZATION.PDF

**PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE):** ______________________________________________

**AUTHORIZED REPRESENTATIVE'S PHONE NUMBER:** ______________________________________________

| PRESCRIBER INFORMATION | |
|---|---|
| **LAST NAME:** | **FIRST NAME:** |
| **PRESCRIBER SPECIALTY:** | **EMAIL ADDRESS:** |
| **NPI NUMBER:** | **DEA NUMBER:** |
| **PHONE NUMBER:** | **FAX NUMBER:** |
| **STREET ADDRESS:** | |
| **CITY:** | **STATE:** **ZIP CODE:** |
| **REQUESTOR** (if different than prescriber)**:** | **OFFICE CONTACT PERSON:** |

| MEDICATION OR MEDICAL DISPENSING INFORMATION | | | |
|---|---|---|---|
| **MEDICATION NAME:** | | | |
| **DOSE/STRENGTH:** | **FREQUENCY:** | **LENGTH OF THERAPY/REFILLS:** | **QUANTITY:** |
| ☐ **NEW THERAPY** ☐ **RENEWAL** **IF RENEWAL:** DATE THERAPY INITIATED: DURATION OF THERAPY (SPECIFIC DATES): | | | |

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Magellan Rx MANAGEMENT

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**1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION?** ☐ YES (if yes, complete below) ☐ NO

| **MEDICATION/THERAPY** (SPECIFY DRUG NAME AND DOSAGE): | **DURATION OF THERAPY** (SPECIFY DATES): | **RESPONSE/REASON FOR FAILURE/ALLERGY:** |
|---|---|---|
| | | |

| **2. LIST DIAGNOSES:** | **ICD-10:** |
|---|---|
| ☐ Plaque psoriasis<br>☐ Psoriatic Arthritis<br>☐ Crohn's Disease<br>☐ Other Diagnosis__________________________ICD-10 Code(s):________________ | |

**3. REQUIRED CLINICAL INFORMATION:** PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.

**Clinical information:**

**Initial Request for all diagnosis:**

**Is drug being used as part of a clinical trial?** ☐ **Yes** ☐ **No**

**Will the patient be using Skyrizi concurrently with a tumor necrosis factor (TNF) inhibitor?** ☐ **Yes** ☐ **No**

**Has the patient had a 3-month trial and inadequate response to the Enbrel(etanercept)?** ☐ **Yes** ☐ **No**
***Must provide documentation, including trial dates.***

**Has the patient had a 3-month trial and inadequate response to the Humira (adalimumab)?** ☐ **Yes** ☐ **No**
***Must provide documentation, including trial dates.***

**Initial Request for Plaque Psoriasis:**
**Is prescriber a dermatologist?** ☐ **Yes** ☐ **No**

**Does the patient have plaques covering at least 3% of their body surface area (BSA) or less than 3% of BSA with involvement of palms, soles, head and neck, or genitalia which cause disruption of normal activities?** ☐ **Yes** ☐ **No**

**Has the patient had an inadequate response to topical therapy (e.g., corticosteroids, anthralin, calcipotriene, tazarotene)?** ☐ **Yes** ☐ **No** ***Must provide documentation, including trial dates.***

**Select if the patient has had a trial and inadequate response to the following phototherapy options:**
☐ **Psoralens with UVA light (PUVA )** ☐ **UVB with coal tar**

**Select if the patient has had a trial and inadequate response to the following systemic therapies:**
☐ **Acitretin** ☐ **Cyclosporine** ☐ **Methotrexate** ***Must provide documentation, including trial dates.***

**Does the patient have documentation of a contraindication to all oral systemic therapies?** ☐ **Yes** ☐ **No**
***Must provide documentation.***

**Renewal Request for Plaque Psoriasis:**
**Is prescriber a dermatologist?** ☐ **Yes** ☐ **No**

**Is patient continuing to respond to therapy?** ☐ **Yes** ☐ **No** ***Must provide documentation***

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**Initial Request for Psoriatic Arthritis:**
**Is prescriber a dermatologist or rheumatologist?** ☐ Yes ☐ No

**Does the patient have documented active disease?** ☐ Yes ☐ No ***Must provide documentation***

**Has the patient had a trial and failed previous therapy with oral disease modifying anti-rheumatic agents (DMARDs, e.g., methotrexate, sulfasalazine (Azulfidine), leflunamide(Arava), or cyclosporine)?** ☐ Yes ☐ No
***Must provide documentation and dates of therapy***

**Renewal Request for Psoriatic Arthritis:**
**Is prescriber a dermatologist or rheumatolgist ?** ☐ Yes ☐ No

**Is patient continuing to respond to therapy?** ☐ Yes ☐ No ***Must provide documentation***

**For Crohn's disease, also answer the following:**

**Select if the patient has tried and had an inadequate response, intolerance, or contraindication to the following systemic therapies:**
- ☐ **Glucocorticoid therapy**
- ☐ **Methotrexate**
- ☐ **Azathioprine**
- ☐ **6-mercaptopurine**
- ☐ **5-ASA/mesalamine**

**Please provide supporting documentation, including which agent(s) have been tried and trial dates:** ______________

**Renewal for Crohn's Disease:**
**Is the prescriber a gastroenterologist?** ☐ Yes ☐ No
**Is the patient continuing to have a positive clinical response?** ☐ Yes ☐ No ***Must provide documentation.***

______________________________________________________________________________

______________________________________________________________________________

**Please note:** Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received.

**ATTESTATION:** I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

**Prescriber Signature or Electronic I.D. Verification:** ________________________________ **Date:** ________________

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**FAX THIS FORM TO: 800-424-7640**
**MAIL REQUESTS TO:** Magellan Rx Management Prior Authorization Program
Attn: CP – 4201
P.O. Box 64811
St. Paul, MN 55164-0811

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