

## 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:			
	, chart notes or lab data, to s		ditional documentation that is uest). Information contained in		
tins form is reduced the didn't	mornation and criminal.		URGENT		
MEMBER INFORMATION					
LAST NAME:		FIRST NAME:			
PHONE NUMBER:		DATE OF BIRTH:			
STREET ADDRESS:					
CITY:		STATE: ZIP CODE:			
PATIENT INSURANCE ID NUI	VIBER:				
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):					
PRESCRIBER INFORMATION					
LAST NAME:		FIRST 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:		PY INITIATED:		
DURATION OF THERAPY (SPE	CIFIC DATES):				

Continued on next page.





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MEMBER'S LAST NAME:	MEMBER'S FIRST NAME:				
1. HAS THE PATIENT TRIED ANY OTHER	R MEDICATIONS FOR THIS CONDITION?	YES (if yes, complete below) NO			
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE):	<b>DURATION OF THERAPY</b> (SPECIFY DATES):	RESPONSE/REASON FOR FAILURE/ALLERGY:			
2. LIST DIAGNOSES:		ICD-10:			
<ul><li>□ Plaque psoriasis</li><li>□ Psoriatic Arthritis</li><li>□ Crohn's Disease</li></ul>					
□ Other Diagnosis	ICD-10 Code(s):				
<b>3. REQUIRED CLINICAL INFORMATION:</b> PRIOR AUTHORIZATION.	: PLEASE PROVIDE ALL RELEVANT CLINICA	AL INFORMATION TO SUPPORT A			
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 <u>Plaque Psoriasis</u> : 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?					
Is patient continuing to respond to therapy? ☐ Yes ☐ No *Must provide documentation					

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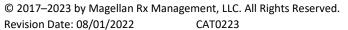
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MEMBER'S LAST NAME:	MEMBER'S FI	RST NAME:
Initial Request for <u>Psoriatic Arthritis</u> : Is prescriber a dermatologist or rheumato	ologist? □ Yes □ No	
Does the patient have documented active	e disease? □ Yes □ No *Must pi	rovide documentation
Has the patient had a trial and failed preve.g., methotrexate, sulfasalazine (Azulfidians *Must provide documentation and dates	ine), leflunamide(Arava), or cycle	nodifying anti-rheumatic agents (DMARDs, osporine)?   Yes   No
Renewal Request for Psoriatic Arthritis: Is prescriber a dermatologist or rheumato	olgist? □ Yes □ No	
Is patient continuing to respond to therap	py? 🗆 Yes 🗆 No *Must provide	documentation
For Crohn's disease, also answer the follo	owing:	
Select if the patient has tried and had an systemic therapies:  Glucocorticoid therapy  Methotrexate  Azathioprine  6-mercaptopurine  5-ASA/mesalamine  Please provide supporting documentation  Renewal for Crohn's Disease:  Is the prescriber a gastroenterologist?  Is the patient continuing to have a positive	n, including which agent(s) have	been tried and trial dates:
Please note: Not all drugs/diagnosis are conformation is received.	overed on all plans. This request i	may be denied unless all required
<b>ATTESTATION:</b> I attest the information pr the Health Plan, insurer, Medical Group or information necessary to verify the accura	r its designees may perform a rou	
Prescriber Signature or Electronic I.D. Ver	rification:	Date:
	notified that any disclosure, copying, dis	ential health information that is legally privileged. If tribution, or action taken in reliance on the contents are notify the sender immediately (via return FAX)

**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



and arrange for the return or destruction of these documents.





