AvMed

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-305-671-0200**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: Skyrizi® SQ & IV (risankizumab) For CD & UC (Pharmacy)

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member AvMed #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy:** _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight (if applicable): _____ **Date weight obtained:** _____

ATTENTION: Skyrizi IV loading dose for treatment of Crohn's disease & Ulcerative colitis can only be billed under the **MEDICAL BENEFIT**. NDC: 00074-5015-01; J2327; 600 mg = 600 billable units, 1200 mg = 1200 billable units

Adult Dosing:

- ❑ **Induction IV: NDC: 00074-5015-01 – Skyrizi IV 600 mg/10 mL – J2327**
  - ❑ **Crohn's disease** – 600 mg administered by IV infusion over a period of at least one hour at week 0, 4 and 8; 600 mg = 600 billable units per dose
  - ❑ **Ulcerative colitis** – 1200 mg administered by IV infusion a period of at least two hours at week 0, 4 and 8; 1200 mg = 1200 billable units per dose
- ❑ **Maintenance SubQ: NDC: 00074-1069-01/00074-1070-01 – Skyrizi SQ 360 mg/ 2.4 mL cartridge; NDC: 00074-1065-01 – Skyrizi SQ 180 mg/ 1.2 mL cartridge. *Use the lowest effective dosage to maintain therapeutic response*.**
  - ❑ 360 mg administered at week 12, and every 8 weeks thereafter
  - ❑ 180 mg administered at week 12, and every 8 weeks thereafter

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NOTE: The Health Plan considers the use of concomitant therapy with more than one biologic immunomodulator (e.g., Dupixent, Entyvio, Humira, Rinvoq, Stelara) prescribed for the same or different indications to be experimental and investigational. Safety and efficacy of these combinations has **NOT** been established and will **NOT** be permitted.

❑ Will the member be discontinuing a previously prescribed biologic if approved for requested medication?

❑ Yes **OR** ❑ No

❑ If yes, please list the medication that will be discontinued and the medication that will be initiated upon approval along with the corresponding effective date.

Medication to be discontinued: _____ **Effective date:** _____

Medication to be initiated: _____ **Effective date:** _____

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

❑ **Diagnosis: Moderate-to-Severe Crohn's disease (CD)**

❑ **Maintenance Dose – 180 mg or 360 mg administered by subcutaneous injection at week 12, and every 8 weeks thereafter**

Authorization Criteria: To be reviewed for approval under the pharmacy benefit

- ❑ Member has a diagnosis of moderate-to-severe **Crohn's disease**
- ❑ Prescribed by or in consultation with a **Gastroenterologist**
- ❑ Member meets **ONE** of the following unless member has a contraindication or intolerance:
  - ❑ Member has tried and failed corticosteroids
  - ❑ Member has tried and failed at least one conventional systemic therapy (e.g., azathioprine, 6-mercaptopurine, or methotrexate)
  - ❑ Member has previously tried and failed another biologic medication other than the requested medication (e.g., adalimumab, Tremfya, ustekinumab)
- ❑ According to the prescriber, the member will receive three induction doses with Skyrizi intravenous within 3 months of initiating maintenance therapy with Skyrizi subcutaneous

❑ **Diagnosis: Moderate-to-Severe Ulcerative Colitis (UC)**

❑ **Maintenance Dose – 180 mg or 360 mg administered by subcutaneous injection at week 12, and every 8 weeks thereafter**

Authorization Criteria: To be reviewed for approval under the pharmacy benefit

- ❑ Member has a diagnosis of moderate-to-severe **ulcerative colitis**
- ❑ Prescribed by or in consultation with a **Gastroenterologist**

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- ❑ Member meets **ONE** of the following unless member has a contraindication or intolerance:
  - ❑ Member has tried and failed corticosteroids
  - ❑ Member has tried and failed at least **ONE** of the following **DMARD**:
    - ❑ 5-aminosalicylates (balsalazide, olsalazine, sulfasalazine)
    - ❑ oral mesalamine (Apriso, Asacol/HD, Delzicol, Lialda, Pentasa)
    - ❑ Other immunosuppressant drug: _____
  - ❑ Member has previously tried and failed another biologic medication other than the requested medication (e.g., adalimumab, Tremfya, ustekinumab)
- ❑ According to the prescriber, the member will receive three induction doses with Skyrizi intravenous within 3 months of initiating maintenance therapy with Skyrizi subcutaneous

❑ **Induction Dose (If required) – One time approval for duration of 2 months, member to receive up to three (3) IV infusion doses**

Authorization Criteria: To be reviewed for one-time approval under the medical benefit

- ❑ Medication will be used as induction therapy
- ❑ Member must meet all maintenance dose authorization criteria above
- ❑ Medication being provided by:
  - ❑ **Location/site of drug administration:** _____
  - ❑ **NPI or DEA # of administering location:**_____
- ❑ Member to receive FDA approved loading dose for **ONE** of the following indications:
  - ❑ Crohn's disease – 600 mg administered by IV infusion over a period of at least one hour at week 0, 4 and 8
  - ❑ Ulcerative colitis – 1200 mg administered by IV infusion a period of at least two hours at week 0, 4 and 8

Medication being provided by a Specialty Pharmacy – Proprium Rx

*****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.*****

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****

***Approved by Pharmacy and Therapeutics Committee:** ~~7/18/2019; 9/16/2022; 7/26/2024; 11/20/2025;~~ **3/26/2026**
REVISED/UPDATED/REFORMATTED: ~~8/13/2019; 11/20/2019; 8/11/2021; 3/3/2022; 3/16/2022; 3/25/2022; 6/15/2022; 6/24/2022; 10/4/2022; 12/23/2022; 2/22/2023; 5/26/2023; 8/12/2024, 12/8/2025;~~ **7/28/2026**