SENTARA HEALTH PLANS

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 1-800-750-9692**. 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 (risankizumab) **For PsO & PsA (Pharmacy) (Preferred)**

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

Member Name: _____

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

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

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

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

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

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

Weight: _____ **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. **Check the diagnosis below that applies.**

❑ **Diagnosis: Moderate-to-Severe Plaque Psoriasis**
Dosing: SubQ: 150 mg at weeks 0, 4, and then every 12 weeks.

- ❑ Member has a diagnosis of **moderate-to-severe plaque psoriasis**
- ❑ Prescribed by or in consultation with a **Dermatologist**
- ❑ Member tried and failed at least **ONE** of either Phototherapy or Alternative Systemic Therapy for at least **three (3) months** **(check each tried below):**

❑ **Phototherapy:** ❑ **UV Light Therapy** ❑ NB UV-B ❑ PUVA	❑ **Alternative Systemic Therapy:** ❑ **Oral Medications** ❑ acitretin ❑ methotrexate ❑ cyclosporine

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❑ Diagnosis: Active Psoriatic Arthritis

Dosing: SubQ: 150 mg at weeks 0, 4, and then every 12 weeks.

- ❑ Member has a diagnosis of active **psoriatic arthritis**
- ❑ Prescribed by or in consultation with a **Rheumatologist**
- ❑ Member tried and failed at least **one (1) DMARD** therapy for at least **three (3) months** **(check each tried below)**:

❑ methotrexate	❑ azathioprine	❑ hydroxychloroquine
❑ sulfasalazine	❑ leflunomide	❑ auranofin
❑ Other: _____		

Medication being provided by a Specialty Pharmacy - PropriumRx

*****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**
REVISED/UPDATED: ~~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;~~ **12/30/2022**