

SENTARA COMMUNITY PLAN (MEDICAID)

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™ (risankizumab-rzaa) Injection

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: _____

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: _____

Diagnosis	Recommended Dose/ Quantity Limit
Plaque Psoriasis/Psoriatic Arthritis	<ul style="list-style-type: none"> • Dosage 150mg Pen or Syringe (one injection) administered by subcutaneous injection at Week 0, Week 4 and every 12 weeks thereafter • Quantity Limit: <ul style="list-style-type: none"> • Two, 150 mg syringes or pen allowed in the initial 28 days • One, 150mg pen/ syringe per 84 days after induction period
Crohn's Disease/Ulcerative Colitis (UC)	<ul style="list-style-type: none"> • IV loading dose 600mg (1200mg for UC) at weeks 0, 4 and 8. Then via subq prefilled cartridge: 180 to 360 mg at week 12 and every 8 weeks thereafter; use lowest effective dosage to maintain therapeutic response • Quantity Limit: <ul style="list-style-type: none"> • One, 180 or 360mg pen/ syringe per 84 days after induction period

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

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 Chronic Plaque Psoriasis

- Member is 18 years of age or older
- Member has a diagnosis of moderate to severe plaque psoriasis for ≥ 6 months with ≥ 1 of the following:
 - Affected body surface area (BSA) of $\geq 10\%$
 - Psoriasis Area and Severity Index (PASI) score ≥ 10
 - Incapacitation due to plaque location (head and neck, palms, soles or genitalia)
- Member did not respond adequately (or is not a candidate) to a 3-month minimum trial of topical agents (anthralin, coal tar preparations, corticosteroids, emollients, immunosuppressives, keratolytics, retinoic acid derivatives, and/or Vitamin D analogues)
- Member did not respond adequately (or is not a candidate) to a 3-month minimum trial of ≥ 1 systemic agent (e.g., immunosuppressives, retinoic acid derivatives, and/or methotrexate)
- Member did not respond adequately (or is not a candidate) to a 3-month minimum trial of phototherapy (e.g., psoralens with UVA light (PUVA) or UVB with coal tar or dithranol)
- Member is not receiving risankizumab-rzaa in combination with another biologic agent for psoriasis or non-biologic immunomodulator (e.g., apremilast, tofacitinib, baricitinib)
- Trial and failure of **TWO (2)** preferred drugs below:

<input type="checkbox"/> adalimumab-adbm (Boehringer Ingelheim) OR Hadlima [®] (adalimumab-bwwd)	<input type="checkbox"/> Enbrel [®]	<input type="checkbox"/> Pyzchiva [®] syringe/vial OR Starjemza [™] (Requires trial and failure of a preferred TNF-alpha inhibitor)
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DIAGNOSIS: Psoriatic Arthritis

- Member has a diagnosis of moderate-to-severe psoriatic arthritis
- Member is 18 years of age or older
- Member did not respond adequately (or is not a candidate) to a 3-month minimum trial of ≥ 1 systemic agent (e.g., immunosuppressives, and/or methotrexate)
- Member is not receiving risankizumab-rzaa in combination with another biologic agent for psoriatic arthritis or non-biologic immunomodulator (e.g., apremilast, tofacitinib, baricitinib)

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- ❑ Trial and failure of **TWO (2)** preferred drugs below:

<input type="checkbox"/> adalimumab-adbm (Boehringer Ingelheim) OR Hadlima [®] (adalimumab-bwwd)	<input type="checkbox"/> Enbrel [®]	<input type="checkbox"/> Pyzchiva [®] syringe/vial OR Starjemza [™] (Requires trial and failure of a preferred TNF-alpha inhibitor)
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❑ DIAGNOSIS: Crohn's Disease

- ❑ Member has a diagnosis of Crohn's Disease
- ❑ Member is 18 years of age or older
- ❑ Trial and failure of a compliant regimen of oral corticosteroids unless contraindicated or intravenous corticosteroids
- ❑ Member is not receiving risankizumab-rzaa in combination with another biologic agent for Crohn's disease or non-biologic immunomodulator (e.g., apremilast, tofacitinib, baricitinib, upadacitinib)
- ❑ Trial and failure of **BOTH** of the preferred drugs below:

<input type="checkbox"/> adalimumab-adbm (Boehringer Ingelheim) OR Hadlima [®] (adalimumab-bwwd)	<input type="checkbox"/> Pyzchiva [®] syringe/vial OR Starjemza [™] (Requires trial and failure of a preferred TNF-alpha inhibitor)
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❑ DIAGNOSIS: Ulcerative Colitis

- ❑ Member has a diagnosis of Ulcerative Colitis
- ❑ Member is 18 years of age or older
- ❑ Trial and failure to **ONE** conventional agent (i.e., 6-mercaptopurine, azathioprine, balsalazide, corticosteroids, cyclosporine, mesalamine, sulfasalazine) for at least a 3-month duration of therapy
- ❑ Member is not receiving risankizumab-rzaa in combination with another biologic agent for ulcerative colitis or non-biologic immunomodulator (e.g., apremilast, tofacitinib, baricitinib, upadacitinib)
- ❑ Trial and failure of **BOTH** of the preferred drugs below:

<input type="checkbox"/> adalimumab-adbm (Boehringer Ingelheim) OR Hadlima [®] (adalimumab-bwwd)	<input type="checkbox"/> Pyzchiva [®] syringe/vial OR Starjemza [™] (Requires trial and failure of a preferred TNF-alpha inhibitor)
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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
- 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- 600mg administered by IV infusion over a period of at least one hour at week 0,4 and 8
 - Ulcerative Colitis: 1200mg administered by IV infusion over a period of at least one hour at week 0, 4 and 8

Medication being provided by 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.****