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	• Dosage 150mg Pen or Syringe (one injection) administered by subcutaneous injection at Week 0, Week 4 and every 12 weeks thereafter. • Quantity Limit: ❑ Two, 150 mg syringes or pen allowed in the initial 28 days. ❑ One, 150mg pen/ syringe per 84 days after induction period. • Dosage 150 mg (2, 75mg injections) administered by subcutaneous injection at Week 0, Week 4 and every 12 weeks thereafter. • Quantity Limit: ❑ Four, 75 mg syringes allowed in the initial 28 days. ❑ Two, 75mg syringe per 84 days after induction period
Crohn's Disease/UC	• 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: ❑ 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

- ❑ Moderate-to-severe plaque psoriasis who are candidates for systemic therapy or phototherapy
- ❑ Patient is ≥ 18 years
- ❑ Diagnosis of moderate to severe plaque psoriasis for ≥ 6 months with ≥ 1 of the following:
  - ❑ Affected body surface area (BSA) of ≥ 10%

    OR
  - ❑ Psoriasis Area and Severity Index (PASI) score ≥ 10

    OR
  - ❑ Incapacitation due to plaque location (head and neck, palms, soles or genitalia)
- ❑ Patient 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, 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:

❑ Humira®	❑ Enbrel®	❑ Infliximab

❑ DIAGNOSIS: Psoriatic Arthritis

- ❑ Diagnosis of moderate-to-severe psoriatic arthritis
- ❑ Patient is ≥ 18 years
- ❑ 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:

❑ Humira®	❑ Enbrel®	❑ Infliximab

❑ DIAGNOSIS: Crohn's Disease OR Ulcerative Colitis

- ❑ Member has **ONE** of the following diagnosis
  - ❑ Moderate-to-severe active **Crohn's Disease**
  - ❑ Moderate-to- severe **Ulcerative Colitis**
- ❑ Patient is ≥ 18 years
- ❑ 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 **TWO (2) PREFERRED** drugs below: Medication will be used as induction therapy

❑ Humira®	❑ Infliximab

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.

❑ 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 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.*

REVISED/UPDATED/REFORMATTED: ~~12/17/2019; 11/23/2020; 7/19/2021;1/5/2022; 7/11/2022; 6/26/2023;~~ ~~12/29/2023;~~ ~~**1/18/2024**~~ **8/27/2024**