BlueCross BlueShield
Federal Employee Program

(risankizumab-rzaa)
SKYRIZI
PRIOR APPROVAL REQUEST

Send completed form to:
FAX: 855-895-3504
FOR URGENT FAX: 844-244-0226

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

Skyrizi (risankizumab-rzaa)

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

NOTE: Form must be completed in its **entirety** for processing

1. Has the patient been on Skyrizi continuously for the last **6 months**, excluding samples? ***Please select answer below:***
   ❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the questions on **PAGE 3**
   ❑**NO** – this is **INITIATION** of therapy, please answer the questions below:

2. Is this request for brand or generic? ❑Brand ❑Generic

3. Has the patient been tested for latent tuberculosis (TB)? ❑Yes* ❑No
   If YES, was the result of the test positive or negative for TB infection? ❑Negative ❑Positive*
   If POSITIVE, has the patient completed treatment or is the patient currently receiving treatment for latent TB? ❑Yes ❑No

4. Does the patient have any active infections including tuberculosis (TB) or hepatitis B virus (HBV)? ❑Yes ❑No

5. Will the patient be given live vaccines while on Skyrizi? ❑Yes ❑No

6. Will Skyrizi be used in combination with another biologic *disease-modifying antirheumatic drug (DMARD) or targeted synthetic DMARD? ❑Yes* ❑No
   If YES, please specify medication: _____
   DMARDs: Actemra, Avsola, Cimzia, Cosentyx, Enbrel, Entyvio, Humira, Ilumya, Inflectra, Kevzara, Kineret, Olumiant, Orencia, Otezla, Remicade, Renflexis, Riabni, Rinvoq, Rituxan, Ruxience, Siliq, Simponi/Simponi Aria, Stelara, Taltz, Tremfya, Truxima, and Xeljanz/Xeljanz XR

7. What is the patient's diagnosis?
   ❑Crohn's Disease (CD)
   a. Does the prescriber agree to monitor liver enzymes and bilirubin levels for hepatotoxicity? ❑Yes ❑No
   b. Does the patient have moderately to severely active Crohn's disease? ❑Yes ❑No
   c. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to at least one conventional therapy option? ❑Yes ❑No
   d. Does the prescriber agree to administer Skyrizi within the FDA labeled maintenance dose of 360mg every 8 weeks? ❑Yes ❑No
   e. **Standard/Basic Option Patient for claims adjudicated through the pharmacy benefit**: Is Skyrizi being requested as a change from Cimzia to allow the member access to their copay benefit? ❑Yes ❑No

PLEASE PROCEED TO PAGE 2 FOR ADDITIONAL DIAGNOSES

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PAGE 2 - PHYSICIAN COMPLETES

Patient Name: _____ **DOB:** _____ **Patient ID: R** _____

❑Plaque Psoriasis (PsO)

a. Does the patient have a diagnosis of moderate to severe plaque psoriasis? ❑Yes ❑No

b. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to conventional systemic therapy? ***Please select answer below:***

❑Inadequate response ❑Intolerance or contraindication ❑Has not tried conventional systemic therapy

c. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to phototherapy?

❑Inadequate response ❑Intolerance or contraindication ❑Has not tried phototherapy

d. Does the prescriber agree to dose the patient within the FDA labeled maintenance dose of 150mg every 12 weeks? ❑Yes ❑No

e. **Standard/Basic Option Patient <u>for claims adjudicated through the pharmacy benefit</u>:** Is Skyrizi being requested as a change from Cimzia, Cosentyx, Ilumya, or Siliq so the member can access their copay? ❑Yes***** ❑No

****If YES***, please select medication: ❑Cimzia ❑Cosentyx ❑Ilumya ❑Siliq

❑Psoriatic Arthritis (PsA)

a. Does the patient have active psoriatic arthritis? ❑Yes ❑No

b. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to a three month trial of at least one conventional disease modifying antirheumatic drug (DMARD)? ❑Yes ❑No

c. Does the prescriber agree to dose the patient within the FDA labeled maintenance dose of 150mg every 12 weeks? ❑Yes ❑No

e. **Standard/Basic Option Patient <u>for claims adjudicated through the pharmacy benefit</u>:** Is Skyrizi being requested as a change from Cimzia, Cosentyx, Orencia SC, or Simponi so the member can access their copay? ❑Yes***** ❑No

****If YES***, please select medication: ❑Cimzia ❑Cosentyx ❑Orencia ❑Simponi

❑Other diagnosis ***(please specify)***: _____

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Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

Skyrizi (risankizumab-rzaa)

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3. What is the patient's diagnosis?
   ❑Crohn's Disease (CD)
      a. Does the prescriber agree to monitor liver enzymes and bilirubin levels for hepatotoxicity? ❑Yes ❑No
      b. Does the prescriber agree to administer Skyrizi within the FDA labeled maintenance dose of 360mg every 8 weeks? ❑Yes ❑No
   ❑Plaque Psoriasis (PsO)
      a. Does the prescriber agree to dose the patient within the FDA labeled maintenance dose of 150mg every 12 weeks? ❑Yes ❑No
   ❑Psoriatic Arthritis (PsA)
      a. Does the prescriber agree to dose the patient within the FDA labeled maintenance dose of 150mg every 12 weeks? ❑Yes ❑No
   ❑Other diagnosis ***(please specify)***: _____

4. Has the patient's condition improved or stabilized with Skyrizi? ❑Yes ❑No

5. Does the patient have any active infections including tuberculosis (TB) or hepatitis B virus (HBV)? ❑Yes ❑No

6. Will the patient be given live vaccines while on Skyrizi? ❑Yes ❑No

7. Will Skyrizi be used in combination with another biologic *****disease-modifying antirheumatic drug **(**DMARD) or targeted synthetic DMARD? ❑Yes***** ❑No
   ****If YES***, please specify medication: _____
   ****DMARDs: Actemra, Avsola, Cimzia, Cosentyx, Enbrel, Entyvio, Humira, Ilumya, Inflectra, Kevzara, Kineret, Olumiant, Orencia, Otezla, Remicade, Renflexis, Riabni, Rinvoq, Rituxan, Ruxience, Siliq, Simponi/Simponi Aria, Stelara, Taltz, Tremfya, Truxima, and Xeljanz/Xeljanz XR***