Prescriber Criteria Form Skyrizi 2024 PA Fax 3048-A v1 010124.docx Skyrizi (risankizumab-rzaa) Coverage Determination
This fax machine is located in a secure location as required by HIPAA regulations. Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673**. Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Skyrizi (risankizumab-rzaa).

Drug Name: Skyrizi (risankizumab-rzaa)

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Has the patient previously received the requested drug for one of the following conditions: A) plaque psoriasis, B) psoriatic arthritis, C) Crohn's disease? [If yes, then no further questions.]	Yes	No
2	Is the requested drug prescribed for a patient with moderate to severe plaque psoriasis? [If no, then skip to question 5.]	Yes	No
3	Does the patient meet one of the following criteria: A) at least 3 percent of body surface area is affected by plaque psoriasis at the time of diagnosis, B) crucial body areas (e.g., feet, hands, face, neck, groin, intertriginous areas) are affected by plaque psoriasis at the time of diagnosis? [If no, then no further questions.]	Yes	No
4	Does the patient meet any of the following criteria: A) patient has experienced an inadequate treatment response or intolerance to either phototherapy (e.g., ultraviolet B [UVB], psoralen plus ultraviolet A [PUVA]) or pharmacologic treatment with methotrexate, cyclosporine, or acitretin, B) pharmacologic treatment with methotrexate, cyclosporine, or acitretin is contraindicated, C) patient has severe psoriasis that warrants a biologic as first-line therapy (i.e., at least 10 percent of the body surface area [BSA] or crucial body areas [e.g., hands, feet, face, neck, scalp, genitals/groin, intertriginous areas] are affected)? [No further questions.]	Yes	No

5	Does the patient have a diagnosis of active psoriatic arthritis? [If yes, then no further questions.]	Yes	No
6	Is the requested drug being prescribed for a patient with moderately to severely active Crohn's disease? [If no, then no further questions.]	Yes	No
7	Does the patient meet either of the following criteria: A) patient has experienced an inadequate treatment response to at least one conventional therapy (e.g., corticosteroids), B) patient has experienced an intolerance or has a contraindication to conventional therapy?	Yes	No

Comments:	_____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.

Prescriber (or Authorized) Signature: _____ **Date:**_____