Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
Skyrizi (risankizumab-rzaa) Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk
Length of Authorization: 12 months

Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **Skyrizi (risankizumab-rzaa) .** Please complete and fax this form back to Kaiser Permanente within 24 hours [fax: 1-866-331-2104]. If you have any questions or concerns, please call 1-866-331-2103. **Requests will not be considered unless this form is complete. The KP-MAS Formulary can be found at:** Pharmacy | Community Provider Portal | Kaiser Permanente

1 – Patient Information

Patient Name: _____ Kaiser Medical ID#: _____ Date of Birth: _____

2 – Provider Information

Provider Name: _____ Specialty: _____ Provider NPI: _____

Provider Address: _____

Provider Phone #: _____Provider Fax #: _____

Please check the boxes that apply:
□ Initial Request □ Continuation of Therapy Request

3 – Pharmacy Information

Pharmacy Name: _____ Pharmacy NPI: _____

Pharmacy Phone #_____ Pharmacy Fax #: _____

4 – Drug Therapy Requested

Drug 1: Name/Strength/Formulation: _____
Sig: _____

Drug 2: Name/Strength/Formulation: _____
Sig: _____

5– Diagnosis/Clinical Criteria

Initial Therapy:

1. Does the member have diagnosis of one of the following? AND
   □ Plaque Psoriasis (PsO)
   □ Psoriatic Arthritis (PsA)
   □ Crohn's Disease

□ Moderate to severe ulcerative colitis (UC)

□ Other: _____

2. Is the patient ≥ 18 years old?
   □ No □ Yes

3. Is the patient receiving risankizumab-rzaa in combination with another biologic agent for psoriasis or non-biologic immunomodulator (e.g., apremilast, tofacitinib, baricitinib)?

   □ No □ Yes
   If, Yes, therapy will not be approved.

4. Has the member tried and failed (or has a contraindication to) preferred products?

   □ No □ Yes

   If yes, indicate therapy tried and outcome_____

   _____

Plaque psoriasis (PSO):

1. Does the patient have moderate-to-severe plaque psoriasis for at least 6 months? AND

   □ No □ Yes

2. Is there involvement of at least 10% of body surface area (BSA)? OR

   □ No □ Yes

3. Is the Psoriasis Area and Severity Index (PASI) score 10 or greater? OR

   □ No □ Yes

4. Incapacitation due to plaque location (e.g., head and neck, palms, soles or genitalia)? AND

   □ No □ Yes

5. Has the patient not responded adequately (or is not a candidate) to a 3 month minimum trial of topical agents (e.g., anthralin, coal tar preparations, corticosteroids, emollients, immunosuppressives, keratolytics, retinoic acid derivatives, and/or Vitamin D analogues)? AND

   □ No □ Yes

6. Has the patient not responded adequately (or is not a candidate) to a 3 month minimum trial of at least 1 systemic agent (e.g. Immunosuppressives, retinoic acid derivatives, and/or methotrexate)? AND

   □ No □ Yes

7. Has the patient not responded 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)? AND

   □ No □ Yes

Psoriatic Arthritis (PsA)

1. Has the patient not responded adequately (or is not a candidate) to a 3 month minimum trial of ≥ 1 systemic agent (e.g. Immunosuppressives, and/or methotrexate)
   □ No □ Yes

Crohn's Disease

1. Has the patient had a trial and failure of a compliant regimen of oral corticosteroids unless contraindicated or intravenous corticosteroids?
   □ No □ Yes

Moderate to severe ulcerative colitis (UC)

1. Has the patient tried and failed to ONE conventional agent (i.e., 6-mercaptopurine, azathioprine, balsalazide, corticosteroids, cyclosporine, mesalamine, sulfasalazine) used in the treatment of UC after at least a 3-month duration of therapy
   □ No □ Yes

6 – Provider Sign-Off

Additional Information –

1. **Please submit chart notes/medical records for the patient that are applicable to this request.**
2. **If member has not tried preferred agent(s) please provide rationale/explanation and any additional supporting information that should be taken into consideration for the requested medication:**

_____

_____

_____

I certify that the information provided is accurate. Supporting documentation is available for State audits.

Provider Signature:	**Date:**