Skyrizi (risankizumab-rzaa)
Prior Authorization Request Form

Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

MEMBER'S LAST NAME: _____ **MEMBER'S FIRST NAME:** _____

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

☐ **URGENT**

MEMBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PHONE NUMBER:	**DATE OF BIRTH:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
PATIENT INSURANCE ID NUMBER:	

☐ **MALE** ☐ **FEMALE** **HEIGHT (IN/CM):** _____ **WEIGHT (LB/KG):** _____ **ALLERGIES:** _____

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: PRIMETHERAPEUTICS.COM/NOPP

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): _____

AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: _____

PRESCRIBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PRESCRIBER SPECIALTY:	**EMAIL ADDRESS:**
NPI NUMBER:	**DEA NUMBER:**
PHONE NUMBER:	**FAX NUMBER:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
REQUESTOR (if different than prescriber)**:**	**OFFICE CONTACT PERSON:**

MEDICATION OR MEDICAL DISPENSING INFORMATION			
MEDICATION NAME:			
DOSE/STRENGTH:	**FREQUENCY:**	**LENGTH OF THERAPY/REFILLS:**	**QUANTITY:**
☐ **NEW THERAPY** ☐ **RENEWAL** **IF RENEWAL:** DATE THERAPY INITIATED: DURATION OF THERAPY (SPECIFIC DATES):			

Continued on next page.

Revision Date: 7/1/25

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1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? ☐ YES (if yes, complete below) ☐ NO		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE)**:**	**DURATION OF THERAPY** (SPECIFY DATES)**:**	**RESPONSE/REASON FOR FAILURE/ALLERGY:**

2. LIST DIAGNOSES:	**ICD-10:**
☐ Plaque psoriasis ☐ Psoriatic Arthritis ☐ Crohn's Disease ☐ Ulcerative Colitis ☐ Other Diagnosis_____ICD-10 Code(s):_____	

3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.

Clinical information:
Initial Request for all diagnosis:
Is drug being used as part of a clinical trial? ☐ Yes ☐ No

Will the patient be using Skyrizi concurrently with another biologic or other immunomodulatory agents ? ☐ Yes ☐ No

Has the patient had a 3-month trial and inadequate response to the biosimilar for Humira-adalimumab-aacf? ☐ Yes ☐ No **Must provide documentation, including trial dates.*

Does patient have a absolute contraindication to the biosimilar for the biosimilar for Humira-adalimumab-aacf? ☐ Yes ☐ No Please submit documentation.

Has the patient tried and had an inadequate response to a 4- month trial of the biosimilar for Stelara-Otulfi(ustekinumb-aauz)? ☐ Yes ☐ No Please submit documentation.

Does patient have a absolute contraindication to the biosimilar for Stelara-Otulfi(ustekinumb-aauz)? ☐ Yes ☐ No Please submit documentation.

Initial Request for Plaque Psoriasis:
Is prescriber a dermatologist? ☐ Yes ☐ No

Does the patient have plaques covering at least 10% of their body surface area (BSA) or less than 10% of BSA with involvement of palms, soles, head and neck, or genitalia which cause disruption of normal activities? ☐ Yes ☐ No

Has the patient had an inadequate response to topical therapy (e.g., corticosteroids, anthralin, calcipotriene, tazarotene)? ☐ Yes ☐ No **Must provide documentation, including trial dates.*

Select if the patient has had a trial and inadequate response to the following phototherapy options:
☐ Psoralens with UVA light (PUVA) ☐ UVB with coal tar

Select if the patient has had a trial and inadequate response to the following systemic therapies:

MEMBER'S LAST NAME: _____ **MEMBER'S FIRST NAME:** _____

□ **Acitretin** □ **Cyclosporine** □ **Methotrexate** ***Must provide documentation, including trial dates.***

Does the patient have documentation of a contraindication to all oral systemic therapies? □ **Yes** □ **No**
Must provide documentation.

Initial Request for Psoriatic Arthritis:
Is prescriber a dermatologist or rheumatologist? □ **Yes** □ **No**
Will the patient be using Skyrizi concurrently with another biologic or other immunomodulatory agents ? □ **Yes** □ **No**

Does the patient have documented active disease? □ **Yes** □ **No** ***Must provide documentation***

Has the patient had a trial and failed previous therapy with oral disease modifying anti-rheumatic agents (DMARDs, e.g., methotrexate, sulfasalazine (Azulfidine), leflunamide(Arava), or cyclosporine)? □ **Yes** □ **No**
Must provide documentation and dates of therapy

For Initial Request for Crohn's disease, also answer the following:
Select if the patient has tried and had an inadequate response, intolerance, or contraindication to the following systemic therapies:
- □ **Glucocorticoid therapy**
- □ **Methotrexate**
- □ **Azathioprine**
- □ **6-mercaptopurine**
- □ **5-ASA/mesalamine**

Please provide supporting documentation, including which agent(s) have been tried and trial dates:
_____

Initial Request for Ulcerative Colitis:
Is the prescriber a gastroenterologist? □ **Yes** □ **No**
Will the patient be using Skyrizi concurrently with another biologic or other immunomodulatory agents ? □ **Yes** □ **No**
Select if the patient has tried and had an inadequate response, intolerance, or contraindication to the following systemic therapies:
- □ **Glucocorticoid therapy**
- □ **Methotrexate**
- □ **Azathioprine**
- □ **6-mercaptopurine**

Please provide supporting documentation, including which agent(s) have been tried and trial dates:
_____

Renewal Requests:
Is the prescriber one of the below? □ **Yes** □ **No**
□ **gastroenterologist**
□ **dermatologist**
□ **rheumatologist**
Will the patient be using Skyrizi concurrently with another biologic or other immunomodulatory agents ? □ **Yes** □ **No**

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Is the patient continuing to have a positive clinical response? □ **Yes** □ **No** ***Must provide documentation***

Please note: Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received.

ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature or Electronic I.D. Verification: _____ **Date:** _____

FAX THIS FORM TO: 800-424-7640
MAIL REQUESTS TO: Prime Therapeutics Management Prior Authorization Program
Attn: CP – 4201
P.O. Box 64811
St. Paul, MN 55164-0811