Skyrizi

Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-866-249-6155.** If you have questions regarding the prior authorization, please contact CVS Caremark at **1-866-814-5506.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____
Request Initiated For: _____

1. What is the diagnosis?
   ❑ Moderate to severe plaque psoriasis
   ❑ Other _____
2. What is the ICD-10 code? _____
3. Is this request for continuation of therapy? ❑ Yes ❑ No *If No, skip to #7*
4. Is the patient currently receiving Skyrizi through samples or a manufacturer's patient assistance program?
   If Yes or Unknown, skip to #7. ❑ Yes ❑ No ❑ Unknown
5. How long has the patient been receiving the requested medication? _____ weeks / months (circle one)
   If less than 4 months, no further questions.
6. Has the patient achieved or maintained positive clinical response to treatment as evidenced by low disease activity or improvement in signs and symptoms since starting treatment with Skyrizi?
   If Yes, no further questions. ❑ Yes ❑ No
7. Has the patient received any of the following medications? *If Yes, please indicate the most recent medication.*
   ❑ Actemra ❑ Cimzia ❑ Cosentyx ❑ Enbrel ❑ Humira ❑ Ilumya ❑ Inflectra ❑ Kevzara ❑ Olumiant
   ❑ Orencia ❑ Otezla ❑ Remicade ❑ Renflexis ❑ Siliq ❑ Simponi ❑ Simponi Aria ❑ Stelara ❑ Taltz
   ❑ Tremfya ❑ Xeljanz ❑ Xeljanz XR ❑ No
8. Has the patient undergone pretreatment screening for latent tuberculosis (TB) infection with either a TB skin test or an interferon gamma release assay (e.g., QFT-GIT, T-SPOT.TB)? ❑ Yes ❑ No
9. What is the percentage of body surface area (BSA) affected (prior to starting the requested medication)?
   _____ %
10. *If less than 5% of BSA affected,* are crucial body areas (e.g., hands, feet, face, neck, scalp, genitals/groin, intertriginous areas) affected? ❑ Yes ❑ No

Send completed form to: Case Review Unit, CVS Caremark Prior Authorization Fax: 1-866-249-6155

11. Has the patient experienced an inadequate response, or has an intolerance to phototherapy (e.g., UVB, PUVA) or pharmacologic treatment with methotrexate, cyclosporine or acitretin?
    If Yes, no further questions. ❑ Yes ❑ No

12. Does the patient have a clinical reason to avoid pharmacologic treatment with methotrexate, cyclosporine or acitretin? ❑ Yes ❑ No
    If Yes, indicate clinical reason: _____

13. Does the patient have severe psoriasis that warrants a biologic DMARD as first-line therapy? ❑ Yes ❑ No

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____
Prescriber or Authorized Signature **Date (mm/dd/yy)**

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