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.

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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 prescribed dose and frequency?
   a) Loading dose:
   - ❑ Skyrizi 75mg Quantity and Frequency: _____
   - ❑ Skyrizi 150mg Quantity and Frequency: _____
   - ❑ Skyrizi 360mg Quantity and Frequency: _____
   - ❑ Skyrizi 600mg Quantity and Frequency: _____
   - ❑ Other: _____

   b) Maintenance dose:
   - ❑ Skyrizi 75mg Quantity and Frequency: _____
   - ❑ Skyrizi 150mg Quantity and Frequency: _____
   - ❑ Skyrizi 360mg Quantity and Frequency: _____
   - ❑ Other: _____

2. What is the diagnosis?
   - ❑ Moderate to severe plaque psoriasis
   - ❑ Active psoriatic arthritis WITH co-existent plaque psoriasis
     Please indicate primary diagnosis being treated:
     ❑ Active psoriatic arthritis ❑ Moderate to severe plaque psoriasis
   - ❑ Active psoriatic arthritis WITHOUT co-existent plaque psoriasis
   - ❑ Moderately to severely active Crohn's disease
   - ❑ Other _____

3. What is the ICD-10 code? _____

4. Is the requested drug being prescribed by or in consultation with any of the following?
   ❑ Dermatologist ❑ Rheumatologist ❑ Gastroenterologist ❑ None of the above

5. Will the requested drug be used in combination with any other biologic (e.g., Humira) or targeted synthetic drug (e.g., Olumiant, Otezla, Xeljanz)? ❑ Yes ❑ No

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6. Has the patient ever received (including current utilizers) a biologic (e.g., Humira) or targeted synthetic drug (e.g., Olumiant, Xeljanz) associated with an increased risk of tuberculosis? *If Yes, skip to #10* ❑ Yes ❑ No

7. Has the patient had a tuberculosis (TB) test (e.g., tuberculosis skin test [PPD], interferon-release assay [IGRA], chest x-ray) within 6 months of initiating therapy? ❑ Yes ❑ No

8. What were the results of the tuberculosis (TB) test?
❑ Positive for TB ❑ Negative for TB, *skip to #10* ❑ Unknown

9. Which of the following applies to the patient?
❑ Patient has latent TB and treatment for latent TB has been initiated
❑ Patient has latent TB and treatment for latent TB has been completed
❑ Patient has latent TB and treatment for latent TB has not been initiated
❑ Patient has active TB

10. Is the patient currently receiving Skyrizi? ❑ Yes ❑ No *If diagnosis is Crohn's disease skip to #12*

11. Is this request for continuation of therapy with the requested drug?
❑ Yes ❑ No *If No, skip to diagnosis section.*

12. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program? *If Yes or Unknown, skip to diagnosis section.* ❑ Yes ❑ No ❑ Unknown

13. Has the patient achieved or maintained positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition since starting treatment with the requested drug?
❑ Yes ❑ No

Complete the following section based on the patient's <u>primary</u> diagnosis, if applicable.

<u>Section A: Moderate to Severe Plaque Psoriasis</u>
Continuation

14. Has the patient experienced a reduction in body surface area (BSA) affected from baseline? ***ACTION REQUIRED: If Yes, please attach chart notes or medical record documentation of decreased body surface area affected and no further questions.*** ❑ Yes ❑ No

15. Has the patient experienced an improvement in signs and symptoms of the condition from baseline (e.g.,itching, redness, flaking, scaling, burning, cracking, pain)? ***ACTION REQUIRED: If Yes, please attach chart notes or medical record documentation of improvement in signs and symptoms.*** ❑ Yes ❑ No

Initiation

16. Has the patient ever received (including current utilizers) a biologic (e.g., Humira) or targeted synthetic drug (e.g., Sotyktu, Otezla) indicated for the treatment of moderate to severe plaque psoriasis? ***ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried and no further questions.*** ❑ Yes ❑ No

17. Are crucial body areas (e.g., hands, feet, face, neck, scalp, genitals/groin, intertriginous areas) affected? ***ACTION REQUIRED: If Yes, please attach chart notes or medical record documentation of affected areas and no further questions.*** ❑ Yes ❑ No

18. What is the percentage of body surface area (BSA) affected (prior to starting the requested medication)? _____% ***ACTION REQUIRED: Please attach chart notes or medical record documentation of body surface area affected.*** *If greater than or equal to 10% of BSA, no further questions.*

19. 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? ***ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy and no further questions.*** ❑ Yes ❑ No

20. Does the patient have a clinical reason to avoid pharmacologic treatment with methotrexate, cyclosporine, and acitretin? ***ACTION REQUIRED: If Yes, please attach documentation of clinical reason to avoid therapy.***
❑ Yes ❑ No ***If Yes, indicate clinical reason:*** _____

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Section B: Active Psoriatic Arthritis

Continuation

21. Which of the following has the patient experienced an improvement in from baseline? ***ACTION REQUIRED: Please attach chart notes or medical record documentation supporting positive clinical response.***
    ❑ Number of swollen joints ❑ Number of tender joints ❑ Dactylitis
    ❑ Enthesitis ❑ Skin and/or nail involvement ❑ Axial disease
    ❑ None of the above

Initiation

22. Has the patient ever received (including current utilizers) a biologic (e.g., Humira) or targeted synthetic drug (e.g., Rinvoq, Otezla) that is indicated for active psoriatic arthritis? ***ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried and no further questions.*** ❑ Yes ❑ No

23. Does the patient have mild to moderate disease? ❑ Yes ❑ No *If No, skip to #29*

24. Does the patient have enthesitis or predominantly axial disease? *If Yes, no further questions*. ❑ Yes ❑ No

25. Has the patient had an inadequate response to methotrexate, leflunomide, or another conventional synthetic drug (e.g., sulfasalazine) administered at an adequate dose and duration? ***ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy and no further questions.*** ❑ Yes ❑ No

26. Has the patient had an intolerance to methotrexate, leflunomide, or another conventional synthetic drug (e.g., sulfasalazine)? ***ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy and no further questions.*** ❑ Yes ❑ No

27. Does the patient have a contraindication to methotrexate or leflunomide? ***ACTION REQUIRED: If Yes, please attach documentation of clinical reason to avoid therapy and no further questions.*** ❑ Yes ❑ No
    If Yes, indicate clinical reason: _____

28. Does the patient have a contraindication to another conventional synthetic drug (e.g., sulfasalazine)? ***ACTION REQUIRED: If Yes, please attach documentation of clinical reason to avoid therapy.***
    ❑ Yes ❑ No *No further questions.*

29. Does the patient have severe disease? ❑ Yes ❑ No

Section C: Moderately to Severely Active Crohn's Disease

30. Is this request for initiation or continuation of treatment with Skyrizi?
    ❑ Initiation of the intravenous (IV) loading dose, *skip to #33*
    ❑ Initiation of the subcutaneous (SQ) maintenance dose, *skip to #33*
    ❑ Continuation of the subcutaneous (SQ) maintenance dose

Continuation

31. Has the patient achieved or maintained remission? ***ACTION REQUIRED: If Yes, please attach chart notes or medical record documentation of remission and no further questions.*** ❑ Yes ❑ No

32. Which of the following has the patient experienced improvement in from baseline? ***ACTION REQUIRED: Please attach chart notes or medical record documentation supporting positive clinical response.***
    ❑ Abdominal pain or tenderness ❑ Diarrhea ❑ Body weight
    ❑ Endoscopic appearance of the mucosa ❑ Abdominal mass ❑ Hematocrit
    ❑ Improvement on a disease activity scoring tool (e.g., Crohn's Disease Activity Index (CDAI) score
    ❑ None of the above

Initiation

33. Has the patient ever received (including current utilizers) a biologic (e.g., Humira) indicated for Crohn's disease? ***ACTION REQUIRED: If Yes, attach chart notes, medical record documentation, or claims history supporting previous medications tried and no further questions.*** ❑ Yes ❑ No

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34. Has the patient tried and had an inadequate response to at least one conventional therapy option?
ACTION REQUIRED: If Yes, please attach patient's chart notes, medical record documentation, or claims history of previous medications tried, including response to therapy and no further questions.

- ❑ Yes - Sulfasalazine (Azulfidine, Sulfazine)
- ❑ Yes - Ciprofloxacin (Cipro)
- ❑ Yes - Budesonide (Entocort EC)
- ❑ Yes - Mercaptopurine (Purinethol)
- ❑ Yes - Rifaximin (Xifaxan)
- ❑ Yes - Methotrexate intramuscular (IM) or subcutaneous (SC)
- ❑ Yes - Metronidazole (Flagyl)
- ❑ Yes - Prednisone
- ❑ Yes - Azathioprine (Azasan, Imuran)
- ❑ Yes - Methylprednisolone (Solu-Medrol)
- ❑ Yes - Tacrolimus
- ❑ No - None of the above

35. Does the patient have a contraindication or intolerance to at least one conventional therapy option (e.g.,azathioprine [Azasan, Imuran], budesonide [Entocort EC], ciprofloxacin [Cipro], mercaptopurine [Purinethol], methylprednisolone [Solu-Medrol], methotrexate, metronidazole [Flagyl], prednisone, sulfasalazine [Azulfidine, Sulfazine], rifaximin [Xifaxan], tacrolimus)? ***ACTION REQUIRED: If Yes, attach chart notes, medical record documentation, or claims history supporting previous medications tried (if applicable), including response to therapy. If therapy is if not advisable, please attach documentation of clinical reason to avoid 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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