CVS caremark™ {{PANUMCODE}}

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: {{MEMFIRST}} {{MEMLAST}} **Date**: {{TODAY}}
Patient's ID: {{MEMBERID}} **Patient's Date of Birth:** {{MEMBERDOB}}
Physician's Name: {{PHYFIRST}} {{PHYLAST}}
Specialty: _____, NPI#: _____
Physician Office Telephone: {{PHYSICIANPHONE}} **Physician Office Fax:** {{PHYSICIANFAX}}
Request Initiated For: {{DRUGNAME}}

1. What is the prescribed dose and frequency?
   a) Loading dose:
      ❑ Skyrizi 75mg Quantity and Frequency: _____
      ❑ Other: _____
   b) Maintenance dose:
      ❑ Skyrizi 75mg Quantity and Frequency: _____
      ❑ Other: _____
2. What is the diagnosis? ❑ Moderate to severe plaque psoriasis ❑ Other _____
3. What is the ICD-10 code? _____
4. Will the requested drug be used in combination with any other biologic (e.g., Humira) or targeted synthetic disease-modifying anti-rheumatic drug (DMARD) (e.g., Olumiant, Otezla, Xeljanz)? ❑ Yes ❑ No
5. Has the patient ever received (including current utilizers) a biologic (e.g., Humira) or targeted synthetic DMARD (e.g., Olumiant, Xeljanz) associated with an increased risk of tuberculosis? *If Yes, skip to #7* ❑ Yes ❑ No
6. 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? *If Yes, skip to #9* ❑ Yes ❑ No
7. Does the patient have risk factors for tuberculosis (TB) (e.g., persons with close contact to people with infectious TB disease; persons who have recently immigrated from areas of the world with high rates of TB [e.g., Africa, Asia, Eastern Europe, Latin America, Russia]; children less than 5 years of age who have a positive TB test; groups with high rates of TB transmission [e.g., homeless persons, injection drug users, persons with HIV infection], or persons who work or reside with people who are at an increased risk for active TB [e.g., hospitals, long-term care facilities, correctional facilities, homeless shelters])? ❑ Yes ❑ No *If No, skip to #12*
8. Has the patient been tested for tuberculosis (TB) within the previous 12 months? ❑ Yes ❑ No
9. What were the results of the tuberculosis (TB) test?
   ❑ Positive for TB ❑ Negative for TB, *skip to #12* ❑ Unknown
10. Does the patient have latent or active tuberculosis (TB)? ❑ Latent ❑ Active ❑ Unknown

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

11. Has treatment for latent tuberculosis (TB) infection been initiated or completed?
    ❑ Yes – treatment initiated ❑ Yes – treatment completed ❑ No

12. Is this request for continuation of therapy with the requested drug? ❑ Yes ❑ No *If No, skip to #17*

13. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program? *If Yes or Unknown, skip to #17* ❑ Yes ❑ No ❑ Unknown

14. 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 *No further questions*

15. 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. ❑ Yes ❑ No

16. 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 *No further questions*

17. Has the patient ever received (including current utilizers) Otezla or a biologic (e.g., Humira) 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

18. 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 body surface area affected and no further questions. ❑ Yes ❑ No

19. 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 affected areas and body surface area affected.*** *If greater than or equal to 10% of BSA, no further questions*

20. 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

21. 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: _____

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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