USFHP Prior Authorization Request Form for
risankizumab on body **(Skyrizi OBI)**

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be faxed to 855-273-5735

OR

The patient may attach the completed form to the prescription and **mail** it to:

Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? Call 1-877-880-7007

https://www.usfamilyhealth.org/for-providers/pharmacy-information/

Prior authorization does not expire. Clinical documentation may be required.

Step 1

Please complete patient and physician information (please print):

Patient Name:	______	Physician Name:	______
Address:	______	Address:	______
	______		______
Sponsor ID #	______	Phone #:	______
Date of Birth:		Secure Fax #:	

Step 2

Please complete the clinical assessment:

Question		
1. The provider acknowledges a trial of Humira is required before Skyrizi OBI.	☐ Acknowledged Proceed to question **2**	
2. Is the patient 18 years of age or older?	☐ Yes proceed to question **3**	☐ No **STOP** **Coverage not approved**
3. Has the patient tried and had an inadequate response to Humira?	☐ Yes proceed to question **6**	☐ No proceed to question **4**
4. Does the patient have a contraindication to Humira?	☐ Yes proceed to question **6**	☐ No proceed to question **5**
5. Has the patient experienced an adverse reaction to Humira that is not expected to occur with Skyrizi?	☐ Yes proceed to question **6**	☐ No **STOP** **Coverage not approved**

Continue on next page

Question		
6. What is the indication or diagnosis?	☐ Moderately to severely active Crohn's disease - proceed to question **7** ☐ Moderately to severely active ulcerative colitis - proceed to question **7** ☐ Other diagnosis - **STOP - Coverage not approved**	
7. Will the patient be receiving other targeted immunomodulatory biologics with the requested medication, including but not limited to the following: TNF inhibitors, IL-1, IL-6, IL-17, IL-23, IL-36, S1p, JAK inhibitors?	☐ Yes **STOP** **Coverage not approved**	☐ No **Sign and date below**

Step 3

I certify the above is true to the best of my knowledge. Please sign and date:

Prescriber Signature ____________________ Date ____________

[28 May 2025]