US Family Health Plan
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**

Medical documentation may be required. Failure to provide could result in denial.

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:**

1. Use of the Skyrizi on-body injector for non-FDA-approved indications, including plaque psoriasis or psoriatic arthritis is not approved. Providers should fill out the PA for Skyrizi pen and syringes for indications other than Crohn's disease.	☐ 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. Does the patient have a diagnosis of moderately to severely active Crohn's disease?	☐ Yes proceed to question **4**	☐ No **STOP** **Coverage not approved**
4. Has the patient tried and had an inadequate response to Humira AND Stelara?	☐ Yes proceed to question **7**	☐ No proceed to question **5**
5. Does the patient have a contraindication to Humira AND Stelara?	☐ Yes proceed to question **7**	☐ No proceed to question **6**
6. Has the patient experienced an adverse reaction to Humira AND Stelara that is not expected to occur with the requested agent?	☐ Yes proceed to question **7**	☐ No **STOP** **Coverage not approved**

Continue on next page

7. Has the patient had an inadequate response to non-biologic systemic therapy? (For example: methotrexate, aminosalicylates [for example, sulfasalazine, mesalamine], corticosteroids, immunosuppressants [for example, azathioprine], etc.)	☐ Yes proceed to question **8**	☐ No **STOP** **Coverage not approved**
8. Does the patient have evidence of a negative TB test result in the past 12 months (or TB is adequately managed)?	☐ Yes proceed to question **9**	☐ No **STOP** Coverage not approved
9. Will the patient be receiving other targeted immunomodulatory biologics with the requested medication, including but not limited to the following: Actemra, Cimzia, Cosentyx, Enbrel, Humira, Ilumya, Kevzara, Kineret, Olumiant, Orencia, Otezla, Remicade, Rituxan, Siliq, Simponi, Stelara, Taltz, or Xeljanz/Xeljanz XR?	☐ Yes **STOP** Coverage not approved	☐ No **Sign and date below**

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

Prescriber Signature _____ Date _____