US Family Health Plan

Prior Authorization Request Form for

Risankizumab Pen And Syringe (Skyrizi)

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**

Clinical 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. Humira is the Department of Defense's preferred targeted biologic agent. Has the patient tried Humira?	☐ Yes proceed to question **2**	☐ No proceed to question **4**
2. Has the patient had an inadequate response to Humira?	☐ Yes proceed to question **5**	☐ No proceed to question **3**
3. Has the patient experienced an adverse reaction to Humira that is not expected to occur with the requested agent?	☐ Yes proceed to question **5**	☐ No **STOP** **Coverage not approved**
4. Does the patient have a contraindication to Humira (adalimumab)?	☐ Yes proceed to question **5**	☐ No **STOP** **Coverage not approved**
5. Has the patient tried and experienced an inadequate response, had an adverse reaction, or have a contraindication to Cosentyx (secukinumab)?	☐ Yes proceed to question **6**	☐ No **STOP** **Coverage not approved**
6. Has the patient tried and experienced an inadequate response, had an adverse reaction, or have a contraindication to Stelara (ustekinumab)?	☐ Yes proceed to question **7**	☐ No **STOP** **Coverage not approved**

Continue on next page

7. Is the patient 18 years of age or older?	☐ Yes proceed to question **8**	☐ No **STOP** **Coverage not approved**
8. Is this medication being used for Crohn's disease? Please Note: Skyrizi pen/syringes is not indicated for Crohn's disease. Please consider changing to Skyrizi on-body (OBI) formulation and complete the Skyrizi PA form.	☐ Yes **STOP** **Coverage not approved**	☐ No proceed to question **9**
9. What is the indication or diagnosis?	☐ Moderate to severe plaque psoriasis who is a candidate for phototherapy or systemic therapy - proceed to question **10** ☐ Active psoriatic arthritis (PsA) - proceed to question **10** ☐ Other - **STOP Coverage not approved**	
10. 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 **11**	☐ No **STOP** **Coverage not approved**
11. 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 **12**	☐ No **STOP** **Coverage not approved**
12. 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**

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

Prescriber Signature _____ Date _____

[18 November 2022]