USFHP Prior Authorization Request Form for

Risankizumab pen/syringes **(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

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:**

1. The provider acknowledges that Taltz is available for treatment of plaque psoriasis without the requirement to try Humira.	☐ 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. Is this medication being used for Crohn's disease or ulcerative colitis? **Please Note:** Skyrizi pen/syringes is not indicated for Crohn's disease or ulcerative colitis. Please consider changing to Skyrizi on-body (OBI) formulation and complete the Skyrizi PA form.	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **4**
4. What is the indication or diagnosis?	☐ Active psoriatic arthritis (PsA) - Proceed to question **5** ☐ Moderate to severe plaque psoriasis who is a candidate for phototherapy or systemic therapy - Proceed to question **5** ☐ Other - **STOP Coverage not approved**	
5. Has the patient had an inadequate response to Humira?	☐ Yes proceed to question **8**	☐ No proceed to question **6**

6. Has the patient experienced an adverse reaction to Humira that is not expected to occur with Skyrizi?	☐ Yes Proceed to question **8**	☐ No Proceed to question **7**
7. Does the patient have a contraindication to Humira (adalimumab)?	☐ Yes Proceed to question **8**	☐ No **STOP** **Coverage not approved**
8. Has the patient had an inadequate response, intolerance, or contraindication to non-biologic systemic therapy? [For example: methotrexate, aminosalicylates, (for example, sulfasalazine, mesalamine), corticosteroids, immunosuppressants (for example, azathioprine)].	☐ 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: TNF inhibitors, IL-1, IL-6, IL-17, IL-23, IL-36, 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 _____