Mountain-Pacific Quality Health
Partnering within our communities to provide solutions for better health
P.O. Box 5119, Helena, MT 59604
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Montana Healthcare Programs Prior Authorization Request Form for Use of Skyrizi® (risankizumab-rzaa)

Member name:	DOB:	Date:
Member ID:	Prescriber phone:	
Prescriber name and specialty if applicable:	Prescriber fax:	
Dosage requested:		

Please complete below information for applicable situation, Initiation or Continuation of therapy:

☐ **INITIATION OF THERAPY**

Please check appropriate diagnosis and complete corresponding information:

1. **Active Psoriatic Arthritis**
   a. Member is 18 years of age or older: ☐ Yes ☐ No

   b. Member has a diagnosis of psoriatic arthritis: ☐ Yes ☐ No

   c. Medication is prescribed by, or in consultation with: ☐ Rheumatologist

      Action Required: If not written by a specialist, a copy of the annual specialty consult is required (please attach copy of consult).

      Name of specialist: _____ **Contact date**: _____

   d. Member has trialed, and had an inadequate response or contraindication to a Montana Healthcare Programs preferred drug with the same indication: ☐ Yes ☐ No

      Drug name: _____ **Dates of use**: _____

   e. Provider attests to the following:
      - ☐ The member has been screened for tuberculosis (TB) prior to initiating treatment
      - ☐ The provider will monitor for active infection
      - ☐ The member will avoid the use of live vaccines

   f. Provider attests that member will **not** use Skyrizi® concomitantly with other biologics: ☐ Yes ☐ No

LIMITATIONS:

Maximum dose allowed: 150mg subcutaneous (Sub Q) at week zero, week four and every 12 weeks thereafter

Initial authorization will be issued for three doses (weeks zero, four, and 16).

2. **Moderate to Severe Plaque Psoriasis**
   a. Member is 18 years of age or older: ☐ Yes ☐ No

   b. Member has a diagnosis of moderate to severe plaque psoriasis: ☐ Yes ☐ No

   c. Medication is prescribed by, or in consultation with: ☐ Dermatologist ☐ Rheumatologist

   Action Required: If not written by a specialist, a copy of the annual specialty consult is required (please attach copy of consult).

   Name of specialist: _____ **Contact date**: _____

   d. Member has trialed, and had an inadequate response or contraindication to a Montana Healthcare Programs preferred drug with the same indication: ☐ Yes ☐ No

   Drug name: _____ **Dates of use**: _____

   e. Provider attests to the following:
      - ☐ The member has been screened for TB prior to initiating treatment
      - ☐ The provider will monitor for active infection
      - ☐ The member will avoid the use of live vaccines

   f. Provider attests that member will **not** use Skyrizi® concomitantly with other biologics: ☐ Yes ☐ No

LIMITATIONS:
Maximum dose allowed: 150mg Sub Q at week zero, week four and every 12 weeks thereafter

Initial authorization will be issued for three doses (weeks zero, four and 16).

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3. **Moderately to Severely Active Crohn's Disease**
   a. Member is 18 years of age or older: ☐ Yes ☐ No

   b. Member has a diagnosis of moderately to severely active Crohn's disease: ☐ Yes ☐ No

   c. Medication is prescribed by, or in consultation with: ☐ Gastroenterologist

   Action Required: If not written by a specialist, a copy of the annual specialty consult is required (please attach copy of consult).

   Name of specialist: _____ **Contact date**: _____

   d. Member has trialed, and had an inadequate response or contraindication to a Montana Healthcare Programs preferred drug with the same indication: ☐ Yes ☐ No

   Drug name: _____ **Dates of use:** _____

e. Provider attests to the following:
   - ☐ The member has been screened for TB prior to initiating treatment
   - ☐ The provider will monitor for active infection
   - ☐ The member will avoid the use of live vaccines
   - ☐ Provider will monitor liver enzymes and bilirubin levels at baseline, during induction and up to at least 12 weeks of treatment

f. Provider attests that member will **not** use Skyrizi® concomitantly with other biologics: ☐ Yes ☐ No

LIMITATIONS:
Maximum dose allowed:

- Initial intravenous infusion for induction: 600mg at week zero, week four and week eight
- Maintenance dosage: 180mg or 360mg Sub Q at week 12, then every eight weeks thereafter

Initial authorization will be issued for four doses (infusion weeks zero, four and eight with injection week being week 12).

☐ **CONTINUATION OF THERAPY**

1. Member has been adherent to Skyrizi®:☐ Yes ☐ No

2. Member has documentation of positive clinical response to Skyrizi® therapy (e.g., reduction in the frequency and/or severity of symptoms and exacerbations):☐ Yes ☐ No

3. Annual specialist consult attached if prescriber is not a specialist: ☐ Yes ☐ No ☐ N/A - prescriber is a specialist

4. Provider attests that member will **not** use Skyrizi® concomitantly with other biologics: ☐ Yes ☐ No

Reauthorization will be issued for 1 year.

Please complete form, including required attachments and fax to
Drug Prior Authorization Unit at 1-800-294-1350