Member Name: {{MEMFIRST}} {{MEMLAST}} **DOB:** {{MEMBERDOB}} **PA Number:** {{PANUMBER}}

{{PANUMCODE}}

{{DISPLAY_PAGNAME}}
{{PACDESCRIPTION}}

This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to {{COMPANY_NAME}} at {{CLIENT_PAG_FAX}}. Please contact {{COMPANY_NAME}} at {{CLIENT_PAG_PHONE}} with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of {{DRUGNAME}}.

Patient's Name: {{MEMFIRST}} {{MEMLAST}} **Date**: {{TODAY}}
Patient's ID: {{MEMBERID}} **Patient's Date of Birth:** {{MEMBERDOB}}
Physician's Name: {{PHYFIRST}} {{PHYLAST}} **Patient Phone:** <<MEMPHONE>>
Specialty: _____ **NPI#:** _____
Physician Office Telephone: {{PHYSICIANPHONE}} **Physician Office Fax:** {{PHYSICIANFAX}}
Physician Office Address: <<PHYADDRESS1>> <<PHYADDRESS2>> <<PHYCITY>>, <<PHYSTATE>> <<PHYZIP>>
Drug Name: {{DRUGNAME}}

Quantity: _____ **Frequency:** _____ **Strength:** _____
Route of Administration: _____ **Expected Length of Therapy:** _____
Diagnosis: <<DIAGNOSIS>> **ICD Code**: <<ICD9>>

1. What is the prescribed dose and frequency?
   a) Loading dose:
   ❑ Skyrizi 150mg Quantity and Frequency: _____
   ❑ Skyrizi 360mg Quantity and Frequency: _____
   ❑ Skyrizi 600mg Quantity and Frequency: _____
   ❑ Other: _____
   b) Maintenance dose:
   ❑ Skyrizi 150mg Quantity and Frequency: _____
   ❑ Skyrizi 360mg Quantity and Frequency: _____
   ❑ Other: _____

2. What is the diagnosis?
   ❑ Moderate to severe plaque psoriasis
   ❑ Active psoriatic arthritis WITH co-existent plaque psoriasis
   Please indicate primary diagnosis being treated:
      ❑ Active psoriatic arthritis
      ❑ Moderate to severe plaque psoriasis
   ❑ Active psoriatic arthritis WITHOUT co-existent plaque psoriasis
   ❑ Moderately to severely active Crohn's disease
   ❑ Moderately to severely active Ulcerative colitis
   ❑ Other _____

3. What is the ICD-10 code? _____

4. Will the requested drug be used in combination with any other biologic (e.g., Humira) or targeted synthetic drug (e.g., Otezla, Xeljanz) for the same indication? ❑ Yes ❑ No

5. Is the requested drug being prescribed by or in consultation with any of the following?
   ❑ Gastroenterologist ❑ Rheumatologist ❑ Dermatologist ❑ None of above

6. Has the patient ever received (including current utilizers) a biologic (e.g., Humira) or targeted synthetic drug (e.g., Olumiant, Xeljanz) associated with an increased risk of tuberculosis? *If Yes, skip to #10* ❑ Yes ❑ No

7. Has the patient had a tuberculosis (TB) test (e.g., tuberculosis skin test [TST], interferon-release assay [IGRA]) within 6 months of initiating therapy? ❑ Yes ❑ No

8. What were the results of the tuberculosis (TB) test?
   ❑ Positive for TB ❑ Negative for TB, *skip to #10* ❑ Unknown

9. Which of the following applies to the patient?
   - ❑ Patient has latent TB and treatment for latent TB has been initiated
   - ❑ Patient has latent TB and treatment for latent TB has been completed
   - ❑ Patient has latent TB and treatment for latent TB has not been initiated
   - ❑ Patient has active TB

10. Is this request for continuation of therapy with the requested drug?
    ❑ Yes ❑ No *If No, skip to #13*

11. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program? *If Yes or Unknown, skip #13* ❑ Yes ❑ No ❑ Unknown

12. Has the patient achieved or maintained a positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition since starting treatment with the requested drug?
    ❑ Yes ❑ No

13. Is the patient currently receiving the requested drug? ❑ Yes ❑ No

Complete the following section based on the patient's <u>primary</u> diagnosis, if applicable.

<u>Section A: Moderate to Severe Plaque Psoriasis</u>

Continuation

1. Has the patient experienced a reduction in body surface area (BSA) affected from baseline?
   ACTION REQUIRED: If Yes, please attach chart notes or medical record documentation of decreased body surface area affected and no further questions. ❑ Yes ❑ No

2. Has the patient experienced an improvement in signs and symptoms of the condition from baseline (e.g.,itching, redness, flaking, scaling, burning, cracking, pain)? ***ACTION REQUIRED: If Yes, please attach chart notes or medical record documentation of improvement in signs and symptoms.*** ❑ Yes ❑ No

Initiation

3. Has the patient ever received or is currently receiving a biologic (e.g., Humira) or targeted synthetic drug (e.g., Sotyktu, Otezla) indicated for the treatment of moderate to severe plaque psoriasis (excluding receiving the drug via samples or a manufacturer's patient assistance program)? ***ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried and no further questions.*** ❑ Yes ❑ No

4. Are crucial body areas (e.g., hands, feet, face, neck, scalp, genitals/groin, intertriginous areas) affected?
   ACTION REQUIRED: If Yes, please attach chart notes or medical record documentation of affected areas and no further questions. ❑ Yes ❑ No

5. Is the percentage of body surface area (BSA) affected (prior to starting the requested medication) less than 3%?
   If Yes, no further questions. ❑ Yes ❑ No

6. What is the percentage of body surface area (BSA) affected (prior to starting the requested medication)?
   _____% ***ACTION REQUIRED**: Please attach chart notes or medical record documentation of body surface area affected.* *If greater than or equal to 10% of BSA, no further questions.*

7. Has the patient experienced an inadequate response, or has an intolerance to phototherapy (e.g., UVB, PUVA) or pharmacologic treatment with methotrexate, cyclosporine, or acitretin? ***ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy and no further questions.*** ❑ Yes ❑ No

8. Does the patient have a clinical reason to avoid pharmacologic treatment with methotrexate, cyclosporine, and acitretin? ***ACTION REQUIRED: If Yes, please attach documentation of clinical reason to avoid therapy.***
   ❑ Yes ❑ No ***If Yes, please indicate the clinical reason to avoid pharmacologic treatment with methotrexate, cyclosporine, and acitretin:*** _____

<u>Section B: Psoriatic Arthritis</u>

1. Which of the following has the patient experienced an improvement in from baseline? ***ACTION REQUIRED: Please attach chart notes or medical record documentation supporting positive clinical response.***
   - ❑ Number of swollen joints
   - ❑ Number of tender joints
   - ❑ Dactylitis
   - ❑ Enthesitis
   - ❑ Skin and/or nail involvement
   - ❑ Functional status
   - ❑ C-reactive protein (CRP)
   - ❑ None of the above

Initiation

2. Has the patient ever received or is currently receiving a biologic (e.g., Humira) or targeted synthetic drug (e.g., Rinvoq, Otezla) that is indicated for the treatment of active psoriatic arthritis (excluding receiving the drug via samples or a manufacturer's patient assistance program)? ***ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried and no further questions.*** ❑ Yes ❑ No

3. What is the patient's disease severity? ❑ Mild to moderate ❑ Severe *If No, no further questions.*

4. Does the patient have enthesitis? *If Yes, no further questions.* ❑ Yes ❑ No

5. Has the patient had an inadequate response to methotrexate, leflunomide, or another conventional synthetic drug (e.g., sulfasalazine) administered at an adequate dose and duration? ***ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy and no further questions.*** ❑ Yes ❑ No

6. Has the patient had an intolerance to methotrexate, leflunomide, or another conventional synthetic drug (e.g., sulfasalazine)? ***ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy and no further questions.*** ❑ Yes ❑ No

7. Does the patient have a contraindication to methotrexate or leflunomide? ***ACTION REQUIRED: If Yes, please attach documentation of clinical reason to avoid therapy and no further questions.*** ❑ Yes ❑ No

   If Yes, indicate the contraindication methotrexate or leflunomide: _____

8. Does the patient have a contraindication to another conventional synthetic drug (e.g., sulfasalazine)? ***ACTION REQUIRED: If Yes, please attach documentation of clinical reason to avoid therapy.*** ❑ Yes ❑ No

Section C: Moderately to Severely Active Crohn's Disease

1. Which of the following applies to this request for the requested drug?
   ❑ Initiation of the intravenous (IV) loading dose, *no further questions*
   ❑ Initiation of the subcutaneous (SQ) maintenance dose, *no further questions*
   ❑ Continuation of the subcutaneous (SQ) maintenance dose

Continuation

2. Has the patient achieved or maintained remission OR achieved or maintained a positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition since starting treatment with the requested drug? ***ACTION REQUIRED: If Yes, please attach chart notes or medical record documentation of remission.***
   ❑ Yes, achieved or maintained remission *, no further questions*
   ❑ Yes, achieved or maintained a positive clinical response
   ❑ None of the above, *no further questions*

3. Which of the following has the patient experienced improvement in from baseline? ***ACTION REQUIRED: Please attach chart notes or medical record documentation supporting positive clinical response.***
   ❑ Abdominal pain or tenderness
   ❑ Diarrhea
   ❑ Body weight
   ❑ Abdominal mass
   ❑ Hematocrit
   ❑ Appearance of the mucosa on endoscopy, computed tomography enterography (CTE), magnetic resonance enterography (MRE), or intestinal ultrasound
   ❑ Improvement on a disease activity scoring tool (e.g., Crohn's Disease Activity Index (CDAI) score
   ❑ None of the above

Section D: Moderately to Severely Active Ulcerative Colitis (UC)

1. Which of the following applies to this request for the requested drug?
   ❑ Initiation of the intravenous (IV) loading dose, *no further questions*
   ❑ Initiation of the subcutaneous (SQ) maintenance dose, *no further questions*
   ❑ Continuation of the subcutaneous (SQ) maintenance dose

Continuation

2. Has the patient achieved or maintained remission OR achieved or maintained a positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition since starting treatment with the requested drug? ***ACTION REQUIRED: If Yes, please attach chart notes or medical record documentation of remission.***
   - ❑ Yes, achieved or maintained remission *, no further questions*
   - ❑ Yes, achieved or maintained a positive clinical response
   - ❑ None of the above, *no further questions*

3. Which of the following has the patient experienced improvement in from baseline? ***ACTION REQUIRED: Please attach chart notes or medical record documentation supporting positive clinical response.***
   - ❑ Stool frequency
   - ❑ Rectal bleeding
   - ❑ Urgency of defecation
   - ❑ C-reactive protein (CRP)
   - ❑ Fecal calprotectin (FC)
   - ❑ Appearance of the mucosa on endoscopy, computed tomography enterography (CTE), magnetic resonance enterography (MRE), or intestinal ultrasound
   - ❑ Improvement on a disease activity scoring tool (e.g., Ulcerative Colitis Endoscopic Index of Severity [UCEIS], Mayo Score)
   - ❑ None of the above

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

_____

Prescriber (Or Authorized) Signature and Date