BlueCross BlueShield
Federal Employee Program

SKYRIZI
PRIOR APPROVAL REQUEST

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

Skyrizi (risankizumab-rzaa)

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

NOTE: Form must be completed in its **entirety** for processing

1. Has the patient been on this medication continuously for the last **6 months** excluding samples? ***Please select answer below:***
   ❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the questions on **PAGE 3**
   ❑**NO** – this is **INITIATION** of therapy, please answer the questions below:

2. Is this request for brand or generic? ❑Brand ❑Generic

3. Has the patient been tested for latent tuberculosis (TB)? ❑Yes* ❑No
   ****If YES***, was the result of the test positive or negative for TB infection? ❑Positive* ❑Negative
   ****If POSITIVE***, has the patient completed treatment or is the patient currently receiving treatment for latent TB? ❑Yes ❑No

4. Does the patient have any active infections including tuberculosis (TB) or hepatitis B virus (HBV)? ❑Yes ❑No

5. Will the patient be given live vaccines while on this therapy? ❑Yes ❑No

6. Will Skyrizi be used in combination with another biologic DMARD or targeted synthetic DMARD? ❑Yes* ❑No
   ****If YES***, please specify the medication: _____
   ****DMARDs: Actemra or an Actemra biosimilar, Avsola, Bimzelx, Cimzia, Cosentyx, Enbrel, Entyvio, Humira or a Humira biosimilar, Ilumya, Inflectra, Kevzara, Kineret, Olumiant, Orencia, Otezla, Remicade, Renflexis, Riabni, Rinvoq, Rituxan, Ruxience, Siliq, Simponi/Simponi Aria, Skyrizi, Sotyktu, Spevigo, Stelara, Taltz, Tremfya, Truxima, Xeljanz/Xeljanz XR, Zymfentra.***

7. What is the patient's diagnosis?
   ❑Crohn's disease (CD)
   a. Does the prescriber agree to monitor liver enzymes and bilirubin levels for hepatotoxicity? ❑Yes ❑No
   b. Does the patient have moderately to severely active Crohn's disease (CD)? ❑Yes ❑No
   c. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to at least one conventional therapy option? ❑Yes ❑No
   d. Does the prescriber agree not to exceed the FDA labeled maintenance dose of 360 mg every 8 weeks? ❑Yes ❑No
   e. **Standard/Basic Option Patient for claims adjudicated through the pharmacy benefit**: Is this medication being requested as a change from Cimzia, Entyvio, Omvoh, or Zymfentra to allow the member access to their copay benefit? ❑Yes* ❑No ****If YES***, please select medication: ❑Cimzia ❑Entyvio ❑Omvoh ❑Zymfentra

PLEASE PROCEED TO PAGE 2 FOR ADDITIONAL DIAGNOSES

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PAGE 2 - PHYSICIAN COMPLETES

Patient Name: _____ DOB: _____ Patient ID: R _____

❑Plaque psoriasis (PsO)

a. Does the patient have a diagnosis of moderate to severe plaque psoriasis (PsO)? ❑Yes ❑No

b. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to conventional systemic therapy? ***Please select answer below:***

❑Inadequate response ❑Intolerance or contraindication ❑Has not tried conventional systemic therapy

c. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to phototherapy?

❑Inadequate response ❑Intolerance or contraindication ❑Has not tried phototherapy

d. Does the prescriber agree not to exceed the FDA labeled maintenance dose of 150 mg every 12 weeks? ❑Yes ❑No

e. **Standard/Basic Option Patient <u>for claims adjudicated through the pharmacy benefit</u>:** Is this medication being requested as a change from one of the following to allow the member access to their copay benefit: Bimzelx, Cimzia, Cosentyx, Ilumya, Siliq, or Sotyktu? ❑Yes* ❑No

***If YES**, please select medication: ❑Bimzelx ❑Cimzia ❑Cosentyx ❑Ilumya ❑Siliq ❑Sotyktu

❑Psoriatic arthritis (PsA)

a. Does the patient have active psoriatic arthritis (PsA)? ❑Yes ❑No

b. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to a 3-month trial of at least one conventional disease modifying antirheumatic drug (DMARD)? ❑Yes ❑No

c. Does the prescriber agree not to exceed the FDA labeled maintenance dose of 150 mg every 12 weeks? ❑Yes ❑No

e. **Standard/Basic Option Patient <u>for claims adjudicated through the pharmacy benefit</u>:** Is this medication being requested as a change from one of the following to allow the member access to their copay benefit: Bimzelx, Cimzia, Cosentyx, Orencia SC, or Simponi? ❑Yes* ❑No

***If YES**, please select medication: ❑Bimzelx ❑Cimzia ❑Cosentyx ❑Orencia ❑Simponi

❑Ulcerative colitis (UC)

a. Does the prescriber agree to monitor liver enzymes and bilirubin levels for hepatotoxicity? ❑Yes ❑No

b. Does the patient have moderately to severely active ulcerative colitis (UC)? ❑Yes ❑No

c. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to at least one conventional therapy option? ❑Yes ❑No

d. Does the prescriber agree not to exceed the FDA labeled maintenance dose of 360 mg every 8 weeks? ❑Yes ❑No

e. **Standard/Basic Option Patient <u>for claims adjudicated through the pharmacy benefit</u>**: Is this medication being requested as a change from one of the following to allow the member access to their copay benefit: Entyvio, Omvoh, Simponi, Velsipity, Xeljanz/Xeljanz XR, Zeposia, or Zymfentra? ❑Yes* ❑No

***If YES**, please select medication: ❑Entyvio ❑Omvoh ❑Simponi ❑Velsipity ❑ Xeljanz/Xeljanz XR ❑Zeposia ❑Zymfentra

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Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

Skyrizi (isankizumab-rzaa)

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

NOTE: Form must be completed in its **entirety** for processing

1. Has the patient been on this medication continuously for the last **6 months** excluding samples? ***Please select answer below:***
   ❑**NO** – this is **INITIATION** of therapy, please answer the questions on **PAGE 1**
   ❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the question below:

2. Is this request for brand or generic? ❑Brand ❑Generic

3. What is the patient's diagnosis?
   ❑Crohn's disease (CD)
      a. Does the prescriber agree to monitor liver enzymes and bilirubin levels for hepatotoxicity? ❑Yes ❑No
      b. Does the prescriber agree not to exceed the FDA labeled maintenance dose of 360 mg every 8 weeks? ❑Yes ❑No
   ❑Plaque psoriasis (PsO)
      a. Does the prescriber agree not to exceed the FDA labeled maintenance dose of 150 mg every 12 weeks? ❑Yes ❑No
   ❑Psoriatic arthritis (PsA)
      a. Does the prescriber agree not to exceed the FDA labeled maintenance dose of 150 mg every 12 weeks? ❑Yes ❑No
   ❑Ulcerative colitis (UC)
      a. Does the prescriber agree to monitor liver enzymes and bilirubin levels for hepatotoxicity? ❑Yes ❑No
      b. Does the prescriber agree not to exceed the FDA labeled maintenance dose of 360 mg every 8 weeks? ❑Yes ❑No

4. Has the patient's condition improved or stabilized with Skyrizi? ❑Yes ❑No

5 Does the patient have any active infections including tuberculosis (TB) or hepatitis B virus (HBV)? ❑Yes ❑No

6. Will the patient be given live vaccines while on this therapy? ❑Yes ❑No

7. Will Skyrizi be used in combination with another biologic DMARD or targeted synthetic DMARD? ❑Yes* ❑No
   If YES, please specify the medication: _____

   DMARDs: Actemra or an Actemra biosimilar, Avsola, Bimzelx, Cimzia, Cosentyx, Enbrel, Entyvio, Humira or a Humira biosimilar, Ilumya, Inflectra, Kevzara, Kineret, Olumiant, Orencia, Otezla, Remicade, Renflexis, Riabni, Rinvoq, Rituxan, Ruxience, Siliq, Simponi/Simponi Aria, Skyrizi, Sotyktu, Spevigo, Stelara, Taltz, Tremfya, Truxima, Xeljanz/Xeljanz XR, Zymfentra.