

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



{{PANUMCODE}}

## Skyrizi

### Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-866-249-6155.** If you have questions regarding the prior authorization, please contact CVS Caremark at 1-866-814-5506. For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

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**Patient's Name:** {{MEMFIRST}} {{MEMLAST}} **Date:** {{TODAY}}  
**Patient's ID:** {{MEMBERID}} **Patient's Date of Birth:** {{MEMBERDOB}}  
**Physician's Name:** {{PHYFIRST}} {{PHYLAST}}  
**Specialty:** \_\_\_\_\_, **NPI#:** \_\_\_\_\_  
**Physician Office Telephone:** {{PHYSICIANPHONE}} **Physician Office Fax:** {{PHYSICIANFAX}}  
**Request Initiated For:** {{DRUGNAME}}

1. What is the diagnosis?  
 Moderate to severe plaque psoriasis  
 Other \_\_\_\_\_
2. What is the ICD-10 code? \_\_\_\_\_
3. Will the requested drug be used in combination with any other biologic (e.g., Humira) or targeted synthetic disease-modifying anti-rheumatic drug (DMARD) (e.g., Olumiant, Otezla, Xeljanz)?  Yes  No
4. Has the patient ever received (including current utilizers) a biologic (e.g., Humira) or targeted synthetic DMARD (e.g., Olumiant, Xeljanz)? *If Yes, skip to #6*  Yes  No
5. Has the patient had a tuberculosis (TB) test (e.g., tuberculosis skin test [PPD], an interferon-release assay [IGRA], or a chest x-ray) within 6 months of initiating therapy? *If Yes, skip to #8*  Yes  No
6. Does the patient have risk factors for tuberculosis (TB) (e.g., persons with close contact to people with infectious TB disease; persons who have recently immigrated from areas of the world with high rates of TB [e.g., Africa, Asia, Eastern Europe, Latin America, Russia]; children less than 5 years of age who have a positive TB test; groups with high rates of TB transmission [e.g., homeless persons, injection drug users, persons with HIV infection], or persons who work or reside with people who are at an increased risk for active TB [e.g., hospitals, long-term care facilities, correctional facilities, homeless shelters])?  Yes  No *If No, skip to #11*
7. Has the patient been tested for tuberculosis (TB) within the previous 12 months?  Yes  No
8. What were the results of the tuberculosis (TB) test?  
 Positive for TB  Negative for TB, *skip to #11*  Unknown
9. Does the patient have latent or active tuberculosis (TB)?  Latent  Active  Unknown
10. Has treatment for latent tuberculosis (TB) infection been initiated or completed?  
 Yes - treatment initiated  Yes - treatment completed  No
11. Is the patient currently receiving Skyrizi?  Yes  No

**Send completed form to: Case Review Unit, CVS Caremark Prior Authorization Fax: 1-866-249-6155**

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12. Is this request for continuation of therapy with the requested drug?  Yes  No *If No, skip to #15*
13. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program? *If Yes or Unknown, skip to #15.*  Yes  No  Unknown
14. Has the patient achieved or maintained positive clinical response as evidenced by low disease activity or improvement in signs and symptoms since starting treatment with the requested drug?  
 Yes  No *No further questions*
15. Has the patient ever received (including current utilizers) Otezla or a biologic (e.g., Humira) indicated for the treatment of moderate to severe plaque psoriasis? *If Yes, no further questions.*  Yes  No
16. Are crucial body areas (e.g., hands, feet, face, neck, scalp, genitals/groin, intertriginous areas) affected?  
*If Yes, no further questions.*  Yes  No
17. What is the percentage of body surface area (BSA) affected (prior to starting the requested medication)?  
\_\_\_\_\_ % *If greater than or equal to 10% of BSA, no further questions*
18. 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?  
*If Yes, no further questions.*  Yes  No
19. Does the patient have a clinical reason to avoid pharmacologic treatment with methotrexate, cyclosporine or acitretin?  Yes  No  
*If Yes, indicate clinical reason:* \_\_\_\_\_

***I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.***

**X** \_\_\_\_\_

**Prescriber or Authorized Signature**

**Date (mm/dd/yy)**

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