AmeriHealth Caritas North Carolina

# Pharmacy Request for Prior Approval – Skyrizi

**Beneficiary Information**

1. Beneficiary Last Name: _____ 2. First Name: _____
3. Beneficiary ID #: _____ 4. Beneficiary Date of Birth: _____ 5. Beneficiary Gender: _____

**Prescriber Information**

6. Prescriber Name: _____ NPI #: _____
Mailing address: _____ City: _____ State: _____ ZIP: _____
7. Requester Contact Information: _____
Name: _____ Phone #: _____ Fax #: _____

**Drug Information**

8. Drug Name: _____ 9. Dose: _____ 10. Directions: _____
11. Length of Therapy: __up to 30 days __60 days __90 days __120 days __180 days __365 days __Other: _____

**Clinical Information**

**Request for Plaque Psoriasis (Adult):**

1. Does the beneficiary have a documented definitive diagnosis of moderate-to-severe Chronic Plaque Psoriasis? Yes___ No___
2. Is the beneficiary 18 years of age or older? Yes___ No___
3. Is the beneficiary on another injectable biologic immunomodulator? Yes___ No___
4. Has the beneficiary been considered and screened for the presence of latent tuberculosis infection? Yes___ No___
5. Has the beneficiary been tested with Hep B SAG and Core Ab? Yes___ No___
6. Does the beneficiary have a body surface area (BSA) involvement of at least 3%? Yes___ No___
7. Does the beneficiary have involvement of the palms, soles, head and neck, or genitalia, causing disruption in normal daily activities and/or employment? Yes___ No___
8. Has the beneficiary failed to respond to, or has been unable to tolerate phototherapy and **ONE** of the following medications, or beneficiary has contraindications to these treatments: Soriatane (acitretin), Methotrexate, and/or Cyclosporine? Yes___ No___
9. Has the beneficiary had a trial and failure of Cosentyx, Enbrel or Humira or a clinical reason beneficiary cannot try Cosentyx, Enbrel or Humira? Yes___ No___

**Request for Psoriatic Arthritis:**

1. Does the beneficiary have a documented definitive diagnosis of Psoriatic Arthritis? Yes___ No___
2. Is the beneficiary 18 years of age or older? Yes___ No___
3. Is the beneficiary on another injectable biologic immunomodulator? Yes___ No___
4. Has the beneficiary been considered and screened for the presence of latent tuberculosis infection? Yes___ No___
5. Has the beneficiary been tested with Hep B SAG and Core Ab? Yes___ No___
6. Does the beneficiary have a documented inadequate response or inability to take methotrexate? Yes___ No___
7. Has the beneficiary had a trial and failure of Cosentyx, Enbrel or Humira or a clinical reason beneficiary cannot try Cosentyx, Enbrel or Humira? Yes___ No___

**Request for Ulcerative Colitis (Adult):**

1. Does the beneficiary have a diagnosis of ulcerative colitis? Yes___ No___
2. Is the beneficiary 18 years of age or older? Yes___ No___
3. Is the beneficiary on another injectable biologic immunomodulator? Yes___ No___
4. Has the beneficiary been considered and screened for the presence of latent tuberculosis infection? Yes___ No___
5. Has the beneficiary been tested with Hep B SAG and Core Ab? Yes___ No___
6. Has the beneficiary had a trial and failure of Humira, or a clinical reason beneficiary cannot try Humira? Yes___ No___

**Request for FDA Approved Diagnosis Not Listed Above:**

1. Diagnosis: _____
2. Is the beneficiary on another injectable biologic immunomodulator? Yes___ No___
3. Has the beneficiary been considered and screened for the presence of latent tuberculosis infection? Yes___ No___
4. Has the beneficiary been tested with Hep B SAG and Core Ab? Yes___ No___

Signature of Prescriber: _____ Date: _____

***Prescriber signature mandatory**

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

**Fax this form to: 1-877-234-4274, or call Pharmacy Prior Authorization: 1-866-885-1406**