

AvMed

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff; **fax to 1-305-671-0200.** No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: Skyrizi® SQ (risankizumab) For PsO & PsA (Pharmacy) (Preferred)

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member AvMed #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ Length of Therapy: _____

Diagnosis: _____ ICD Code, if applicable: _____

Weight: _____ Date: _____

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied. **Check the diagnosis below that applies.**

Diagnosis: Moderate-to-Severe Plaque Psoriasis

Dosing: SubQ: 150 mg at weeks 0, 4, and then every 12 weeks.

- Member has a diagnosis of **moderate-to-severe plaque psoriasis**
- Prescribed by or in consultation with a **Dermatologist**
- Member tried and failed at least **ONE** of either Phototherapy or Alternative Systemic Therapy for at least **three (3) months** (check each tried below):

Phototherapy:

UV Light Therapy

NB UV-B

PUVA

Alternative Systemic Therapy:

Oral Medications

acitretin

methotrexate

cyclosporine

(Continued on next page)

Diagnosis: Active Psoriatic Arthritis
Dosing: SubQ: 150 mg at weeks 0, 4, and then every 12 weeks.

- Member has a diagnosis of active **psoriatic arthritis**
- Prescribed by or in consultation with a **Rheumatologist**
- Member tried and failed at least **one (1) DMARD** therapy for at least **three (3) months** (check each tried below):

<input type="checkbox"/> methotrexate	<input type="checkbox"/> azathioprine	<input type="checkbox"/> hydroxychloroquine
<input type="checkbox"/> sulfasalazine	<input type="checkbox"/> leflunomide	<input type="checkbox"/> auranofin
<input type="checkbox"/> Other: _____		

Medication being provided by a Specialty Pharmacy - PropriumRx

*****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.*****
****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****