

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 & IV (risankizumab) For CD (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: _____

NOTE: AvMed considers the use of concomitant therapy with more than one biologic immunomodulator (e.g., Dupixent, Entyvio, Humira, Rinvoq, Stelara) prescribed for the same or different indications to be experimental and investigational. Safety and efficacy of these combinations has **NOT** been established and will **NOT** be permitted.

ATTENTION: Skyrizi IV loading dose for treatment of Crohn's disease can only be billed under the **MEDICAL BENEFIT.** NDC: 00074-5015-01; J2327; 600 mg = 600 billable units at weeks 0, 4 and 8

Adult Dosing:

- **Induction IV: NDC: 00074-5015-01 – Skyrizi IV 600 mg/10 mL – J2327**
 - 600 mg administered by IV infusion over a period of at least one hour at week 0, 4 and 8; 600 mg = 600 billable units per dose
- **Maintenance SubQ: NDC: 00074-1069-01/00074-1070-01 – Skyrizi SQ 360 mg/ 2.4 mL cartridge; NDC: 00074-1065-01 – Skyrizi SQ 180 mg/ 1.2 mL cartridge**
 - 360 mg administered at week 12, and every 8 weeks thereafter
 - 180 mg administered at week 12, and every 8 weeks thereafter

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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.

Maintenance Dose – 180 mg or 360 mg administered by subcutaneous injection at week 12, and every 8 weeks thereafter

Authorization Criteria: To be reviewed for approval under the pharmacy benefit

- Member has a diagnosis of moderate-to-severe **Crohn’s disease**
- Prescribed by or in consultation with a **Gastroenterologist**
- Member meets **ONE** of the following:
 - Member has tried and failed budesonide or high dose steroids (40-60 mg prednisone)
 - Member has tried and failed at least **ONE** of the following **DMARD** therapies for at least **three (3) months**
 - 5-aminosalicylates (balsalazide, olsalazine, sulfasalazine)
 - oral mesalamine (Apriso, Asacol/HD, Delzicol, Lialda, Pentasa)

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.

Induction Dose (If required) – One time approval for duration of 2 months, member to receive up to three (3) IV infusion doses

Authorization Criteria: To be reviewed for one-time approval under the medical benefit

- Medication will be used as induction therapy
- Medication being provided by:
 - Location/site of drug administration:** _____
 - NPI or DEA # of administering location:** _____
- Member to receive FDA approved loading dose of 600 mg administered by IV infusion over a period of at least one hour at week 0, 4 and 8

Medication being provided by a Specialty Pharmacy – Proprium Rx

*****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.****