PRIORITY PARTNERS
7231 Parkway Dr., Suite 100
Hanover, MD 21076

JOHNS HOPKINS
HEALTH PLANS

Prior Authorization

JOHNS HOPKINS HEALTH PLANS (MEDICAID)

Skyrizi - Priority Partners MCO

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Johns Hopkins Health Plans at **1-410-424-4607**. Please contact Johns Hopkins Health Plans at **1-888-819-1043** with questions regarding the Prior Authorization process.
When conditions are met, we will authorize the coverage of Skyrizi - Priority Partners MCO.

Drug Name (select from list of drugs shown)
Skyrizi (risankizumab-rzaa)

Quantity Frequency Strength

Route of Administration Expected Length of Therapy

Patient Information
Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone:

Prescribing Physician
Physician Name: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please circle the appropriate answer for each question.

1. Has the plan authorized this medication in the past for this patient (i.e., previous authorization is on file under this plan)? Y N

NOTE: The use of physician samples, or manufacturer product discounts, does not guarantee coverage under the provisions of the medical and/or pharmacy benefit. All pertinent criteria must be met in order to be eligible for benefit coverage.

[If yes, skip to question 8.]

2. Does the patient have any of the following diagnoses: A) uveitis, B) sarcoidosis, C) graft-versus-host disease, D) interleukin-2 toxicity, E) Langerhan's cell histiocytosis, F) Y N

	myositis, G) nephrotic syndrome, H) amyloidosis, I) periodic fever syndrome, J) renal transplant syndrome?	
	[If yes, no further questions.]	
3.	Does the patient have a diagnosis of chronic moderate to severe plaque psoriasis? Y N	
	NOTE: Submission of medical records is required.	
	[If no, no further questions.]	
4.	Does the patient have either of the following: A) body surface area involvement of greater than 5 percent, or B) body surface area involvement of less than or equal to 5 percent, but involves sensitive areas (palms/soles of feet, genitalia and head/neck)? Y N	
	NOTE: Submission of medical records is required.	
	[If no, no further questions.]	
5.	Has the patient tried and had insufficient response to phototherapy or systemic disease-modifying antirheumatic drug (DMARD) therapy with methotrexate? Y N	
	NOTE: Submission of medical records is required.	
	[If no, no further questions.]	
6.	Has the patient tried and had insufficient response to brodalumab, etanercept, adalimumab, or secukinumab? Y N	
	NOTE: Submission of medical records is required.	
	[If no, no further questions.]	
7.	Is the patient 18 years of age or older? Y N	
	[If yes, skip to question 9.]	
	[If no, no further questions.]	
8.	Is the patient experiencing clinical improvement from treatment supported by one of the following outcomes: A) reduction in the signs and symptoms, B) prolonged beneficial clinical response, C) inhibition of structural damage progression, or D) improved physical functioning? Y N	
	NOTE: Submission of medical records is required.	
	[If no, no further questions.]	
9.	Is the requested drug being prescribed for FDA-approved dosages and dosing intervals? Y N	
	NOTE: Submission of medical records is required.	
	[If no, no further questions.]	
10.	Will the requested drug be used concurrently with another biologic disease-modifying antirheumatic drug (DMARD)? Y N	

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is

available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

Prescriber (Or Authorized) Signature and Date