Prior Authorization Request Form for
Risankizumab pen/syringes **(Skyrizi)**

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE
7231 Parkway Drive, Suite 100, Hanover, MD 21076

USFHP Pharmacy Prior Authorization Form

FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Step 1 **Please complete patient and physician information** (please print):

Patient Name: _____ Physician Name: _____
Address: _____ Address: _____
_____ _____
Sponsor ID # _____ Phone #: _____
Date of Birth: Secure Fax #:

Step 2 **Please complete the clinical assessment:**

1. Humira is the Department of Defense's preferred targeted biologic agent. Has the patient tried Humira?	☐ Yes proceed to question **2**	☐ No proceed to question **4**
2. Has the patient had an inadequate response to Humira?	☐ Yes proceed to question **5**	☐ No proceed to question **3**
3. Has the patient experienced an adverse reaction to Humira that is not expected to occur with the requested agent?	☐ Yes proceed to question **5**	☐ No **STOP** **Coverage not approved**
4. Does the patient have a contraindication to Humira (adalimumab)?	☐ Yes proceed to question **5**	☐ No **STOP** **Coverage not approved**
5. Has the patient tried and experienced an inadequate response, had an adverse reaction, or have a contraindication to Cosentyx (secukinumab)?	☐ Yes proceed to question **6**	☐ No **STOP** **Coverage not approved**
6. Has the patient tried and experienced an inadequate response, had an adverse reaction, or have a contraindication to Stelara (ustekinumab)?	☐ Yes proceed to question **7**	☐ No **STOP** **Coverage not approved**

Continue on next page

7. Is the patient 18 years of age or older?	☐ Yes proceed to question **8**	☐ No **STOP** **Coverage not approved**
8. Is this medication being used for Crohn's disease? **Please Note: Skyrizi pen/syringes is not indicated for Crohn's disease. Please consider changing to the Skyrizi on-body (OBI) formulation and complete the Skyrizi PA Form.**	☐ Yes **STOP** **Coverage not approved**	☐ No proceed to question **9**
9. What is the indication or diagnosis?	☐ Moderate to severe plaque psoriasis who is a candidate for phototherapy or systemic therapy - proceed to question **10** ☐ Active psoriatic arthritis (PsA) - proceed to question **10** ☐ Other - **STOP Coverage not approved**	
10. Has the patient had an inadequate response to non-biologic systemic therapy? (For example: methotrexate, aminosalicylates [for example, sulfasalazine, mesalamine], corticosteroids, immunosuppressants [for example, azathioprine], etc.)	☐ Yes proceed to question **11**	☐ No **STOP** **Coverage not approved**
11. Does the patient have evidence of a negative TB test result in the past 12 months (or TB is adequately managed)?	☐ Yes proceed to question **12**	☐ No **STOP** **Coverage not approved**
12. Will the patient be receiving other targeted immunomodulatory biologics with the requested medication, including but not limited to the following: Actemra, Cimzia, Cosentyx, Enbrel, Humira, Ilumya, Kevzara, Kineret, Olumiant, Orencia, Otezla, Remicade, Rituxan, Siliq, Simponi, Stelara, Taltz, or Xeljanz/Xeljanz XR?	☐ Yes **STOP** **Coverage not approved**	☐ No **Sign and date below**

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

_____ _____
Prescriber Signature Date

[18 November 2022]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: