



JOHNS HOPKINS
HEALTHCARE

7231 Parkway Drive, Suite 100, Hanover, MD 21076

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

USFHP Pharmacy Prior Authorization Form

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):

1 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?	<input type="checkbox"/> Yes proceed to question 2	<input type="checkbox"/> No proceed to question 4
2. Has the patient had an inadequate response to Humira?	<input type="checkbox"/> Yes proceed to question 5	<input type="checkbox"/> 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?	<input type="checkbox"/> Yes proceed to question 5	<input type="checkbox"/> No STOP Coverage not approved
4. Does the patient have a contraindication to Humira (adalimumab)?	<input type="checkbox"/> Yes proceed to question 5	<input type="checkbox"/> 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)?	<input type="checkbox"/> Yes proceed to question 6	<input type="checkbox"/> 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)?	<input type="checkbox"/> Yes proceed to question 7	<input type="checkbox"/> No STOP Coverage not approved

Continue on next page

Prior Authorization Request Form for
risankizumab (**Skyrizi**)

7. Is the patient 18 years of age or older?	<input type="checkbox"/> Yes proceed to question 8	<input type="checkbox"/> No STOP Coverage not approved
8. Does this adult patient have a diagnosis of moderate to severe plaque psoriasis who is a candidate for phototherapy or systemic therapy?	<input type="checkbox"/> Yes proceed to question 9	<input type="checkbox"/> No STOP Coverage not approved
9. Has the patient had an inadequate response to non-biologic systemic therapy? (For example: methotrexate, aminosaliclates [e.g. sulfasalazine, mesalamine], corticosteroids, immunosuppressants [e.g. azathioprine], etc.)	<input type="checkbox"/> Yes proceed to question 10	<input type="checkbox"/> No STOP Coverage not approved
10. Does the patient have evidence of a negative TB test result in the past 12 months (or TB is adequately managed)?	<input type="checkbox"/> Yes proceed to question 11	<input type="checkbox"/> No STOP Coverage not approved
11. 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?	<input type="checkbox"/> Yes STOP Coverage not approved	<input type="checkbox"/> No Sign and date below

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

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_____ Prescriber Signature

_____ Date

[29 May 2019]

For Internal Use Only	
<input type="checkbox"/> Approved:	Duration of Approval: ____ month(s)
<input type="checkbox"/> Denied:	Authorized By:
<input type="checkbox"/> Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: