Skyrizi

Express Scripts
Prior Authorization
Phone 1-844-424-8886
Fax 1-877-251-5896

To start your Part D Coverage Determination request, you (or your representative or your doctor or other prescriber) should contact Express Scripts, Inc (ESI):

- You may Call ESI at 1-844-424-8886, 24 hours a day, 7 days a week,
  TTY users: 1-800-716-3231
- You may Fax your request to: 1-877-251-5896 (Attention: Medicare Reviews)
- You may also send your request via email to: medicarepartdparequests@express-scripts.com

Member's Last Name:	Member's First Name:
SCAN ID number:	Date of Birth:
Prescriber's Name:	Contact Person:
Office phone:	Office Fax:

Medication:	Diagnosis:

SECTION A Please answer the following questions

1. θ Yes θ No Will the requested medication be concomitantly used with other biologic DMARDs (e.g., TNF Antagonists, Enbrel, Humira, Kineret, Orencia, Remicade, etc.)?
2. θ Yes θ No Is the prescription written or recommended by a gastroenterologist, dermatologist, or rheumatologist?
3. θ Yes θ No Is the diagnosis or indication for the treatment of moderate to severe plaque psoriasis in adults who are candidates for systemic therapy or phototherapy?
4. θ Yes θ No Is the diagnosis or indication for the treatment of moderately to severely active Crohn's disease in adults?
5. θ Yes θ No Is the diagnosis or indication for the treatment of active psoriatic arthritis in adults?
6. θ Yes θ No Is the diagnosis or indication for the treatment of moderately to severely active ulcerative colitis?
7. θ Yes θ No **FOR PSORIASIS:** Has the member previously used at least one systemic therapy (e.g., methotrexate, cyclosporine, acitretin, etc.) prior to the initiation of risankizumab (Skyrizi) if the member is a candidate for systemic therapy?

8. θ Yes θ No **FOR CROHN'S DISEASE:** Has the member previously used at least one at least one conventional therapy agent (e.g., 6-mercaptopurine, azathioprine, etc.) prior to the initiation of risankizumab (Skyrizi)?

9. θ Yes θ No **FOR PSORIATIC ARTHRITIS:** Has the member previously used at least one conventional Disease-Modifying Anti-Rheumatic Drug (e.g., methotrexate, sulfasalazine, etc.) prior to the initiation of risankizumab (Skyrizi)?

10 θ Yes θ No **FOR ULCERATIVE COLITIS:** Has the member previously used at least one conventional therapy agent (e.g., a corticosteroid, azathioprine, or 6-mercaptopurine, etc.) prior to the initiation of Risankizumab (Skyrizi)?

11 θ Yes θ No Has the member previously used a biologic (e.g., adalimumab (Humira), etanercept (Enbrel), apremilast (Otezla), ustekinumab (Stelara), etc.) or is currently using risankizumab (Skyrizi)?

Please document the symptoms and/or any other information important to this review:

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SECTION B Physician Signature

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PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 1-877-251-5896

Our response time for prescription drug coverage standard requests is 72 hours. If you or your prescriber believe that waiting 72 hours for a standard decision could seriously harm your life, health, or ability to regain maximum function, you can ask for an expedited (fast) decision. If your prescriber indicates that waiting 72 hours could seriously harm your health, we will automatically give you a decision within 24 hours. If you do not obtain your prescriber's support for an expedited request, we will decide if your case requires a fast decision. You cannot request an expedited coverage determination if you are asking us to pay you back for a drug you already received. View our formulary and Prior Authorization criteria online at http://www.villagehealthca.com