Skyrizi® (risankizumab-rzaa) Medication Precertification Request

(All fields must be completed and legible for precertification review.)

Aetna Precertification Notification
Phone: 1-866-752-7021
FAX: 1-888-267-3277

For Medicare Advantage Part B:
Please Use Medicare Request Form

Please indicate: ☐ Start of treatment: Start date ____/____/____
☐ Continuation of therapy, Date of last treatment ____/____/____

Precertification Requested By: _____ Phone: _____ Fax: _____

A. PATIENT INFORMATION

First Name:	Last Name:	DOB:	
Address:	City:	State:	ZIP:
Home Phone:	Work Phone:	Cell Phone:	Email:
Patient Current Weight: ____ lbs or ____ kgs Patient Height: ____ inches or ____ cms		Allergies:	

B. INSURANCE INFORMATION

Aetna Member ID #: _____
Group #: _____
Insured:

Does patient have other coverage? ☐ Yes ☐ No
If yes, provide ID#: _____ Carrier Name: _____
Insured:

Medicare: ☐ Yes ☐ No If yes, provide ID #:

Medicaid: ☐ Yes ☐ No If yes, provide ID #:

C. PRESCRIBER INFORMATION

First Name:		Last Name: *(Check One):* ☐ M.D. ☐ D.O. ☐ N.P. ☐ P.A.			
Address:		City:		State:	ZIP:
Phone:	Fax:	St Lic #:	NPI #:	DEA #:	UPIN:
Provider Email:		Office Contact Name:		Phone:	

Specialty *(Check one):* ☐ **Gastroenterologist** ☐ **Other**: _____

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:

☐ Self-administered ☐ Physician's Office
☐ Outpatient Infusion Center Phone: _____
Center Name: _____
☐ Home Infusion Center Phone: _____
Agency Name: _____
☐ Administration code(s) (CPT): _____
Address: _____

Dispensing Provider/Pharmacy: *Patient Selected choice*

☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Other
Name: _____
Address: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____

E. PRODUCT INFORMATION

Request is for: Skyrizi (risankizumab-rzaa) Dose: _____ **Frequency:** _____

F. DIAGNOSIS INFORMATION - Please indicate primary ICD code and specify any other where applicable.

Primary ICD Code: _____ **Secondary ICD Code:** _____ **Other ICD Code:** _____

G. CLINICAL INFORMATION - Required clinical information must be completed in its entirety for all precertification requests.

For All Requests (clinical documentation required for all requests):

☐ Yes ☐ No Will the requested medication be used in combination with any other biologic (e.g., Humira) or targeted synthetic disease-modifying anti-rheumatic drug (DMARD) (e.g., Olumiant, Otezla, Xeljanz)?

☐ Yes ☐ No Has the patient ever received (including current utilizers) a biologic (e.g., Humira) or targeted synthetic DMARD (e.g., Olumiant, Xeljanz) associated with an increased risk of tuberculosis (TB)?

→ ☐ Yes ☐ No Has the patient had a tuberculosis (TB) test (e.g., tuberculosis skin test [PPD], interferon-release assay [IGRA], chest x-ray) within 6 months of initiating therapy?

→ (Check all that apply): ☐ PPD test ☐ interferon-release assay (IGRA) ☐ chest x-ray

Please enter the results of the tuberculosis (TB) test: ☐ positive ☐ negative ☐ unknown

If positive, please indicate which applies to the patient

☐ latent TB and treatment for latent TB has been initiated
☐ latent TB and treatment for latent TB has been completed
☐ latent TB and treatment for latent TB has not been initiated
☐ active TB

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB

G. CLINICAL INFORMATION *(Continued)* - Required clinical information must be completed for ALL precertification requests.

Crohn's Disease (CD)

Please indicate loading dose at weeks 0, 4 and 8: _____ Please indicate maintenance dose: _____ frequency: _____ weeks

☐ Yes ☐ No Has the patient received 12 weeks of therapy or less (i.e., still receiving the loading dose schedule)?

☐ Yes ☐ No Has the patient been diagnosed with moderately to severely active Crohn's disease (CD)?

☐ Yes ☐ No Is the request for initiation of therapy with the intravenous loading dose?

☐ Yes ☐ No Has the patient ever received (including current utilizers) a biologic (e.g., Humira) indicated for Crohn's disease?

→ ☐ Yes ☐ No Has the patient tried and had an inadequate response to at least one conventional therapy option?

→ ☐ Yes ☐ No Does the patient have a contraindication or intolerance to at least one conventional therapy option (e.g., azathioprine [Azasan, Imuran], budesonide [Entocort EC], ciprofloxacin [Cipro], mercaptopurine [Purinethol], methylprednisolone [Solu-Medrol], methotrexate IM or SC, metronidazole [Flagyl], prednisone, sulfasalazine [Azulfidine, Sulfazine], rifaximin [Xifaxan], tacrolimus)?

→ Please select: ☐ Sulfasalazine (Azulfidine, Sulfazine) ☐ Metronidazole (Flagyl) ☐ Ciprofloxacin (Cipro) ☐ Prednisone ☐ Budesonide (Entocort EC) ☐ Azathioprine (Azasan, Imuran) ☐ Mercaptopurine (Purinethol) ☐ Methotrexate IM or SQ ☐ Methylprednisolone (Solu-Medrol) ☐ Rifaximin (Xifaxan) ☐ Tacrolimus

H. ACKNOWLEDGEMENT

Request Completed By *(Signature Required):* _____ **Date:** ____/____/____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The plan may request additional information or clarification, if needed, to evaluate requests.