

Prescriber Criteria Form
 Skyrizi 2026 PA Fax 3048-A v3 010126.docx
 Skyrizi (risankizumab-rzaa)
 Coverage Determination

This fax machine is located in a secure location as required by HIPAA regulations.
 Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673**. Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Skyrizi (risankizumab-rzaa).

Drug Name:
 Skyrizi (risankizumab-rzaa)

Patient Name:

Patient ID:

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| Patient DOB: | Patient Phone: |
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Prescriber Name:

Prescriber Address:

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|--------------------------|---------------|------------------------|
| City: | State: | Zip: |
| Prescriber Phone: | | Prescriber Fax: |
| Diagnosis: | | ICD Code(s): |

Please circle the appropriate answer for each question.

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| 1 | Has the patient previously received the requested drug for one of the following conditions: A) plaque psoriasis, B) psoriatic arthritis, C) Crohn's disease, D) ulcerative colitis? [If yes, then no further questions.] | Yes | No |
| 2 | Does the patient have a diagnosis of moderate to severe plaque psoriasis? [If no, then skip to question 6.] | Yes | No |
| 3 | Does the patient meet one of the following criteria: A) crucial body areas [e.g., hands, feet, face, scalp, neck, genitals/groin, intertriginous areas] are affected at the time of diagnosis, B) patient has severe psoriasis that warrants a biologic as first-line therapy (i.e., at least 10 percent of the body surface area [BSA] is affected)? [If yes, then no further questions.] | Yes | No |
| 4 | Is at least 3 percent of body surface area (BSA) affected by plaque psoriasis at the time of diagnosis? [If no, then no further questions.] | Yes | No |
| 5 | Does the patient meet either of the following criteria: A) patient has experienced an inadequate treatment response or intolerance to either phototherapy (e.g., ultraviolet B [UVB], psoralen plus ultraviolet A [PUVA]) or pharmacologic treatment with methotrexate, cyclosporine, or acitretin, B) pharmacologic treatment with methotrexate, cyclosporine, or acitretin is contraindicated? [No further questions.] | Yes | No |

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| 6 | Does the patient have a diagnosis of active psoriatic arthritis? [If yes, then no further questions.] | Yes | No |
| 7 | Does the patient have a diagnosis of moderately to severely active Crohn's disease? [If yes, then no further questions.] | Yes | No |
| 8 | Does the patient have a diagnosis of moderately to severely active ulcerative colitis? | Yes | No |

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| Comments: | _____ |
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By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.

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| Prescriber (or Authorized) Signature: _____ | Date: _____ |
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