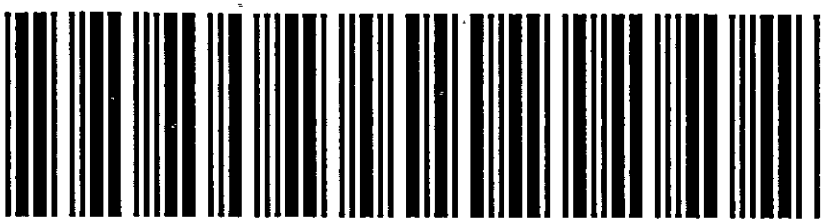
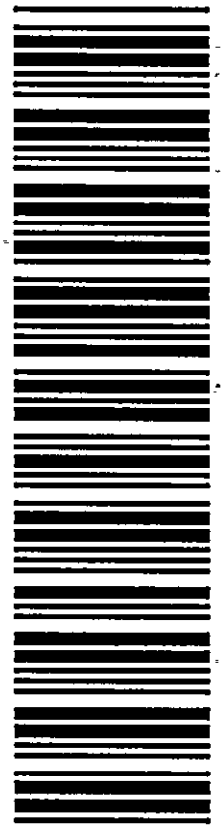


Patch II

9102113870792

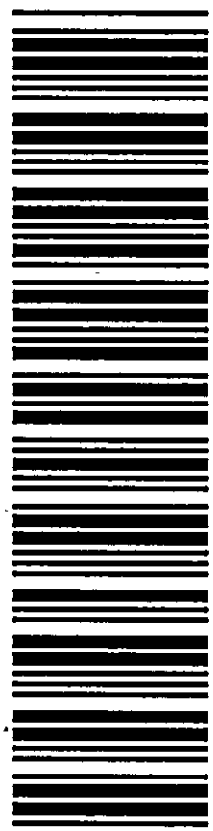


00BREAK00

Document Separator

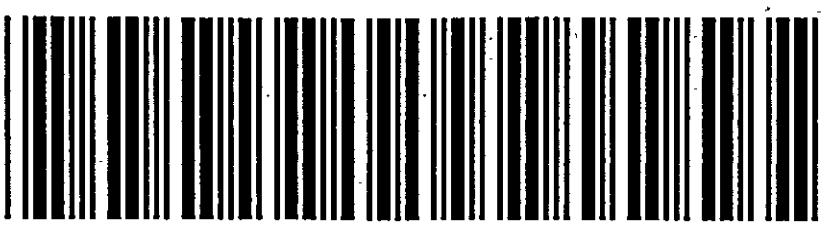
Used to Separate Each Transaction

00BREAK00



SourceHOV, Inc
4050 South 500 West
Salt Lake City, UT 84123

00BREAK00



UnitedHealthcare®

A UnitedHealth Group Company

This document was received in the Appeals P.O. BOX 30573, Salt Lake City, UT, or through fax number 801-938-2109

KB Fax Server 18 RECEIVED 03/31/2021 15:04 2819916907
3/31/2021 3:37:35 PM PAGE 2/002 NURSE STATION
Fax Server

THIS IS AN APPEAL REQUEST

UnitedHealthcare Appeals
PO Bo 30573
Salt Lake City,UT 84130-0573
Fax. 1-801-994-1345

Curtis Paskey
DOB 06/30/1968
ID Number 94535233500
Refe: PA-86216012
ICD10. L40.0 Psoriasis vulgaris
Please see attached Denial Letter and Clinic Notes

I am writing to request coverage for Skyrizi therapy for Curtis Paskey. This letter documents the medical necessity for this therapy in the treatment psoriasis and provides information about the patient's medical history treatment.

Skyrizi is for the treatment of adult patients with moderate to severe chronic plaque psoriasis. Skyrizi is being requested at dosage of 150mg (2-75mg prefilled syringes) at week 0, week 4 then every 12 weeks.

Curtis Paskey has moderate to severe plaque psoriasis, affecting the patient's trunk,arms,legs,chest,scalp,and thighs. The diagnosis code for this condition is L40.0. The patient has tried and failed Topical Steroids, Humira, and Cosentyx. Optum denied coverage of Skyrizi due to the patient not trying Methotrexate. Oral Systemics are avoided due to the patients history of fatty liver disease and ETOH.

In clinical trials, Skyrizi produced high rates of durable skin clearance – most people (82 and 81 percent) treated with Skyrizi achieved 90 percent skin clearance (PASI 90) at one year, with the majority (56 and 60 percent) achieving complete skin clearance (PASI 100). Plaque severity and the location affects the activities of daily living. The patient is currently suffering and the quality of life is being negatively impacted by psoriasis. Aggressive treatment with Skyrizi is necessary to improve life and ability to function.

In my clinical judgment, Skyrizi therapy would provide significant clinical benefit. Skyrizi is medically necessary and appropriate to continue to treat the patient at this stage and course of care. I am enclosing clinical documentation supporting the medical necessity of Skyrizi for this patient. I urge you to provide coverage at this time.

X _____

Christine Hunt, MD
Ph:281-991-5944
Fax:281-991-6907

APR 1 0 2021

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KR Fax Server 16 4/19/2021 12:57:32 PM PAGE 2/002 Fax Server

Internal Fax KR15 4/13/2021 10:07:24 AM PAGE 2/2

Authorized Representative Form-Commercial Appeals & Grievances

A member (or "patient") may use this form to designate an authorized representative to act on his or her behalf regarding a grievance, or an appeal of a denial of service or payment.

Your legal representative may submit the appropriate legal documentation in place of this form. (For example: power of attorney, guardianship papers, foster parent certification or court order). You may be asked to provide additional supporting documentation to accompany this form.

1. **Member/Patient Information:** (Please provide the following information)

First Name: Curtis	Last Name: Paskey	
Address: 0123 North P Street	City: La Porte	State: Texas
Daytime Phone (include area code): 281-308-0988	Member/Patient ID: 945335235500	
Date of Birth (mm/dd/yyyy): 06/30/1968	Reference or claim number (if known): PA-862160 12	
Name of Facility/Provider: (including description e.g.: All appeals/grievances, Date of denial, Service, Payment or Type of care.):		

2. **Person I am authorizing to pursue my appeal/grievance:** (Please provide the following information for your authorized representative)

First Name: Christine	Last Name: Hunt, MD	
Organization/Facility (if applicable):		
Address: 4419 Crenshaw Rd.	City: Pasadena	State: Texas
Daytime Phone: (include area code): 281-991-5944		

3. **Member/Patient:** By signing below I authorize the person named above to act on my behalf and receive information from United Behavioral Health and its subsidiaries in connection with my appeal/grievance. This information may include the following:

All medical and financial information contained in my insurance file, including but not limited to treatment for venereal disease, alcoholism and drug abuse, abortion, mental disorder and HIV status relating to my examination, treatment and hospital confinement in connection with the grievance or determination which is being appealed.

I understand this information is confidential and will only be released as specified in this authorization. This authorization is only valid for 1 year from the date of the signature of Member/Patient or Legal Guardian below.

Signature of Member/Patient or Legal Guardian / Parent if a minor.	Name of Member/Patient or Legal Guardian / Parent if a minor. (Please Print)	Relationship to Member if a minor.	Date
[signature]	Curtis W Paskey	Self	

SIGN HERE

4. **Representative:** By signing below you are certifying you will represent the member to the best of your abilities and do not have a conflict of interest posed by any relationships you may have with the insurance company or providers whom the member is seeking care.

Signature of Authorized Representative	Name of Authorized Representative (Please Print)	Date
[signature]	Christine Hunt, MD	

5. Please include a copy (keep the original) of the adverse determination notice you received.
6. Submit this completed form to AOR Processing via:

Fax to: 866-322-6051

Mail to: AOR Processing
11000 Optum Circle Mail Route
MN103-0600 Eden Prairie, MN
55344

RECEIVED 03/24/2021 09:33 2819916907 NURSE STATION
3/24/2021 9:07:15 AM PAGE 1/009 Fax Server
FSP31407

OPTUMRx

Christine Hunt
4419 Crenshaw Rd
Pasadena, TX 77504

Hours of Operations:
5 a.m. - 10 p.m. PT, Monday-Friday
6 a.m. - 3 p.m. PT, Saturday

Address:
P.O. Box 25183
Santa Ana, CA 92799

Date: 03/24/2021

To: Christine Hunt
Phone: (281)991-5944
Fax: 2819916907
Reference #: PA-86216012
RE: Prior Authorization Request

From: OptumRx
Phone: 1-800-711-4555

Patient Name: Curtis Paskey
Patient DOB: 06/30/1968

Patient ID: 94535233500
Status of Request: Pending

Medication Name: Skyrizi Inj 150dose
GPI/NDC: 9025057070F820

Decision Notes:

The request for coverage for Skyrizi 75mg/0.83ml, use as directed (1 per month), is denied. This decision is based on health plan criteria for Skyrizi. This medicine is covered only if:
You have a history of failure to a 3 month trial of methotrexate at maximally indicated dose within the last 6 months, unless contraindicated or clinically significant adverse effects are experienced (document drug, date, and duration of trial).
The information provided does not show that you meet the criteria listed above.
This case was reviewed in consultation with Denise J. Davis, MD board certified in Obstetrics/Gynecology.

If the treating physician would like to discuss this coverage decision with the physician or health care professional reviewer, please call OptumRx Prior Authorization department at 1-800-711-4555.

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3/24/2021 9:07:15 AM PAGE 2/009 Fax Server
FSP31407

OptumRx Prior Authorization Department
P.O. Box 25183
Santa Ana, CA 92799
URA#: 1786574

THIS IS A NOTICE OF ADVERSE DETERMINATION-PRESCRIPTION DRUG

03/24/2021

Christine Hunt

4419 Crenshaw Rd
Pasadena, TX 77504

Plan member ID: 94535233500
Member Name: Curtis Paskey
Case Number: PA-86216012
Prescriber Name: Christine Hunt
Prescriber Fax: 2819916907
Medication Name: Skyrizi
Re: *Prescription Drug Denial*

Dear Curtis Paskey:

OptumRx is the URA, performing the utilization review on behalf of your UnitedHealthcare plan. OptumRx is responsible for reviewing pharmacy services provided to you by your UnitedHealthcare plan. We received a request from your prescriber for coverage of Skyrizi Inj 150dose. Unfortunately, we must deny coverage for Skyrizi.

The principal reason(s) for denying the prescription drug, the clinical basis, and the screening criteria or guidelines that we used to make the decision are detailed below.

Why was my request denied?
This request was denied because you did not meet the following:

The request was denied due to Lack of Information because your office did not respond to or provide the following requested information as indicated in the Notice of Request for Information.

The request for coverage for Skyrizi 75mg/0.83ml, use as directed (1 per month), is denied. This decision is based on health plan criteria for Skyrizi. This medicine is covered only if:
You have a history of failure to a 3 month trial of methotrexate at maximally indicated dose within the last 6 months, unless contraindicated or clinically significant adverse effects are experienced (document drug, date, and duration of trial).
The information provided does not show that you meet the criteria listed above.
This case was reviewed in consultation with Denise J. Davis, MD board certified in Obstetrics/ Gynecology.

This denial is based on our Skyrizi drug coverage policy, in addition to any supplementary information you or your prescriber may have submitted.

How can I obtain the material(s) used to review this request?
You may request, free of charge, a copy of the drug coverage policy, actual benefit provision, guideline, protocol or other similar criterion on which the denial decision is based, including the diagnosis code and the treatment code and their corresponding meanings, by calling us at 1-800-711-4555, or by writing to us at the address below:

OptumRx

c/o Prior Authorization Guidelines
P.O. Box 25183
Santa Ana, CA 92799

Please note that this decision only affects whether your prescription plan will pay for this medication. Only you and your prescriber can decide what is best for you and your treatment. You may still buy this medication (at full cost) at a local pharmacy.

What if my prescriber wants to discuss this decision with a peer?
Your prescriber or provider of record may request to discuss this decision with a reviewing physician by contacting us at 1-800-711-4555. If the prescriber calls and still disagrees with the initial decision during this discussion, UnitedHealthcare will accept and process the disagreement as an oral appeal.

APPEAL PROCESS

What if I don't agree with this decision?
You have the right to appeal any decision that denies payment for an item or service (in whole or in part). You may also submit written comments, documents, or other information relevant to the appeal.

Who may file an appeal?
The enrollee (you), an individual acting on your behalf (such as an attorney or a friend), or the provider of record, may appeal the adverse determination orally or in writing (see below for further details).

How do I file an appeal?
The appealing party must send us the appeal no later than 180 calendar days after the date of this letter. You, an individual acting on your behalf, or your provider of record, may obtain appeals information, including independent appeal rights, by calling our appeals coordinator using the toll-free member number listed on your health plan ID card. You can also review your plan's prescription drug benefit information or contact your health plan for more detailed information.

There are two ways to appeal:

- **Written Appeal:** To submit a written appeal, mail or fax to the following address or fax number provided below.
- **Oral Appeal:** To file an oral appeal, call the toll-free number noted below.

To file an appeal, please send with it any written comments, documents or other relevant documentation with your appeal to the address listed below:

UnitedHealthcare Appeals
P.O. Box 30573
Salt Lake City, UT 84130-0573

Phone: Please call the toll-free member number listed on your health plan ID card.
Fax: 1-801-994-1345
Expedited/Urgent Fax: 1-801-994-1058

There are four types of appeals required by the Department of Insurance (not all applies to a prescription drug appeal):

- **Standard Appeal:** An appeal that does not involve urgent care such as emergency care, life-threatening conditions, or continued hospitalization.
- **Expedited Appeal:** An expedited appeal is available for a denial of emergency care, a denial of continued hospitalization, or a denial of another service if the requesting health care provider includes a written statement with supporting documentation that the service is necessary to treat a life-threatening condition or prevent serious harm to the patient. An expedited appeal is also available for denials of prescription drugs and intravenous infusions for which the enrollee is currently receiving benefits and for denied step therapy protocol exception requests.

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- **Specialty Appeal:** The provider of record may request a specialty appeal, which requests that a specific type of specialty provider review the denial or the decision denying the appeal.
- **Acquired Brain Injury Appeal:** An appeal of denied services concerning an acquired brain injury.

Appeal Acknowledgment: Within five working days of receipt of the appeal, we will send the appealing party a letter acknowledging the date that we received the appeal and a list of documents that we may need for the appeal. If the appeal is oral, we will send the appealing party a one-page appeal form. The appealing party does not have to return the appeal form but we encourage its return because the form will help us resolve the appeal.

How long does the appeal process take?
The deadlines to resolve the appeal and send a written decision to you, an individual acting on your behalf, or your provider of record are:

- **Standard Appeal:** 30 calendar days of receipt of the appeal.
- **Expedited Appeal:** One (1) working day form the date we received all information necessary to complete the appeal. We may provide the determination by telephone or electronic transmission, but will provide a written determination within three working days of the initial telephonic or electronic notification.
- **Retrospective (Claim) Appeal:** 30 calendar days after receipt of appeal. However, we may extend this deadline once for a period not to exceed 15 days.
- **Acquired Brain Injury Appeal** (this type of appeal may not be applicable in all cases): Not later than three business days after the date on which the individual submits the appeal. The notification of the determination must be provided through a direct telephone contact to the individual making the request. We will provide a written determination within 30 calendar days of receipt of the appeal.
- **Specialty Appeal:** The provider of record may request a specialty appeal, which requests that a specific type of specialty provider review the case. The provider must request this type of appeal within 10 working days from the date the appeal was requested or denied. We will complete the specialty appeal and send our written decision to the enrollee or the person acting on the enrollee's behalf and the provider within 15 working days of receipt of the request for the specialty appeal.
- **Right to an Immediate Review by an IRO:** If the patient has a life-threatening condition or receives a denial for prescription drugs or intravenous infusions for which they are currently receiving benefits, the patient, or someone acting on the patient's behalf, and the provider of record can request an immediate review by an independent review organization (IRO) and is not required to follow our internal appeal procedures. See below for more information about the independent review.

Exhaustion of Internal Appeals Not Required: We will not require exhaustion of our internal appeals process if: (a) we fail to meet our internal appeal process timelines, or (b) the claimant with an urgent care situation files an external review before exhausting our internal appeal process, or (c) we decide to waive the appeal process requirements.

What if my appeal request is urgent?
Your appeal will be accepted and processed as an expedited appeal under the following: (1) emergency care denials (if applicable as related to prescription drugs), (2) denials of care for life-threatening conditions (if applicable as related to prescription drugs), (3) denials of prescription drugs or intravenous infusions for which the patient is currently receiving benefits, and (4) denials of continued stays for hospitalized enrollees (if applicable, as related to prescription drugs), (5) denial of a step therapy protocol exception request, as an expedited appeal.

Quest Diagnostics

Report Status: Fin

PASKEY, CURTIS

Patient Information	Specimen Information	Client Information
PASKEY, CURTIS W DOB: 06/30/1968 AGE: 52 Gender: M Fasting: Y Phone: 281.470.7201 Patient ID: 58528761 Health ID: 8573001330677335	Specimen: HL968636E Requisition: 0005028 Collected: 03/02/2021 / 09:38 CST Received: 03/03/2021 / 00:03 CST Reported: 03/04/2021 / 23:45 CST	Client #: 8176200 HS02MAIL HUNT, CHRISTINE M SOUTHEAST DERMATOLOGY PASADENA 4419 CRENSHAW RD PASADENA, TX 77504-3628

COMMENTS: FASTING:YES

Test Name	In Range	Out Of Range	Reference Range	Lab
QUANTIFERON(R)-TB GOLD PLUS, 1 TUBE	NEGATIVE.		NEGATIVE	RGA
	Negative test result. M. tuberculosis complex infection unlikely.			
NIL	0.03		IU/mL	
MITOGEN-NIL	8.96		IU/mL	
TB1-NIL	0.00		IU/mL	
TB2-NIL	0.04		IU/mL	

The Nil tube value reflects the background interferon gamma immune response of the patient's blood sample. This value has been subtracted from the patient's displayed TB and Mitogen results.

Lower than expected results with the Mitogen tube prevent false-negative Quantiferon readings by detecting a patient with a potential immune suppressive condition and/or suboptimal pre-analytical specimen handling.

The TB1 Antigen tube is coated with the M. tuberculosis-specific antigens designed to elicit responses from TB antigen primed CD4+ helper T-lymphocytes.

The TB2 Antigen tube is coated with the M. tuberculosis-specific antigens designed to elicit responses from TB antigen primed CD4+ helper and CD8+ cytotoxic T-lymphocytes.

For additional information, please refer to https://education.questdiagnostics.com/faq/FAQ204 (This link is being provided for informational/ educational purposes only.)

SE DERM

Visit Note - March 2, 2021

Paskey, Curtis

PRS ID	Sex	DOB	Home	Chart
30480	Male	06/30/1968	(281) 808-0988	135897

Medical History
Reviewed June 2, 2020.
None

Surgical History
Reviewed June 2, 2020.
None

Skin Conditions
Reviewed on June 02, 2020.
Psoriasis

Skin Protection
Reviewed on June 02, 2020.
Do you wear sunscreen?: No
Do you tan in a tanning salon?: No

Family History of Melanoma
Reviewed on June 02, 2020.
Do you have a family history of Melanoma?: No

Social History
Reviewed June 2, 2020.
EtOH less than 1 drink per day
Occupation:
Place of Residence:
Smoking status - Never smoker

Medications
Reviewed June 2, 2020.
clobetasol 0.05 % Topical - Dose: 1 shampoo Frequency: As directed
desonide 0.05 % Topical - Dose: 1 cream Frequency: BID
salicylic acid 6 % Topical - Dose: 1 shampoo Frequency: As directed
clobetasol 0.05 % Scalp - Dose: 1 solution Frequency: QD
Cosentyx Pen (2 Pens) 150 mg/mL Subcutaneous - Dose: 1 pen injector Frequency: as directed

Allergies
Reviewed June 2, 2020.
No known drug allergies

ROS
Provider reviewed on Mar 02, 2021.

A focused review of systems was performed including Allergic / Immunologic.

No Immunosuppression And No Recent Illnesses.

Chief Complaint: Skin Lesions

HPI: This is a 52 year old male who is being seen for a chief complaint of skin lesions, located on the left axillary vault, right axillary vault, chest, and right upper back. The lesions are irritated and red, moderate in severity and have been present for 1 year. He presents today for: evaluation and management.

Exam:

An examination was performed including the scalp (including hair inspection), head (including face), inspection of eyelids, right ear, left ear, neck, back, right upper extremity, left upper extremity, right lower extremity, right axilla, and left axilla.

General Appearance of the patient is well developed and well nourished.

Orientation: alert and oriented x 3.

Mood and affect: in no acute distress.

Data Reviewed:

2 Ordering of each unique test (Vitamin D+Metabolites [Mass/volume] in Serum or Plasma, Mycobacterium tuberculosis tuberculin stimulated gamma interferon [Presence] in Blood)

- Scaling throughout scalp , pink patches, and pink scaly plaques distributed on the
scalp, right axillary vault, left axillary vault, left elbow, right elbow, lower back, right pretibial region, and right thigh

Impression/Plan:

1. Psoriasis
(L40.0)
distributed on the scalp, right axillary vault, left axillary vault, left elbow, right elbow, lower back, right pretibial region, and right thigh.
Associated diagnosis: Pruritus
Status: Worsening
Total Body Surface Area (%): 9.0

Plan: Counseling.
I counseled the patient regarding the following:
Skin care: Emollients, ambient sun exposure, shampoos with tar, selenium or zinc pyrithione can improve psoriasis.
Expectations: Psoriasis is chronic in nature with periods of remissions and flares. Flares can be triggered by stress, infections (group A strep), certain medications.
Contact office if: Psoriasis worsens, or fails to improve despite several months of treatment.

Skyrizi Counseling: I discussed with the patient the risks of risankizumab-rzaa including but not limited to immunosuppression, and serious infections. The patient understands that monitoring is required including a PPD at baseline and must alert us or the primary physician if symptoms of infection or other concerning signs are noted.

Plan: Order Tests.
Labs:
45323-3 - Mycobacterium tuberculosis tuberculin stimulated gamma interferon [Presence] in Blood
35365-6 - Vitamin D+Metabolites [Mass/volume] in Serum or Plasma

Plan: Prescription Medication Management.
Begin the following treatments: Skyrizi.
Discontinue the following treatments: Cosentyx.

Christine Mary Hunt, MD (Primary Provider) (Bill Under)
(281) 991-5944 Work
(281) 991-6910 Fax

Southeast Dermatology, P.A.
4419 Crenshaw Rd
Pasadena, TX 77504