Skyrizi® (risankizumab-rzaa) Medication Precertification Request

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

Aetna Precertification Notification
Phone: 1-866-752-7021 **(TTY:** 711**)**
FAX: 1-888-267-3277

For Medicare Advantage Part B:
Please Use Medicare Request Form

Please indicate: ☑ Start of treatment: Start date 05 / 30 / 2023
☐ Continuation of therapy, Date of last treatment ____ / ____ / ____

Precertification Requested By: _____ Phone: _____ Fax: _____

A. PATIENT INFORMATION

First Name: Akshay	Last Name: Chaudhari	DOB: 02/17/1987	
Address:	City:	State:	ZIP:
Home Phone: 570-599-6973	Work Phone:	Cell Phone:	Email:
Patient Current Weight: ____ lbs or ____ kgs	Patient Height: ____ inches or ____ cms	Allergies:	

B. INSURANCE INFORMATION

Aetna Member ID #: 350410732018
Group #: _____
Insured: Self

Does patient have other coverage? ☐ Yes ☑ No
If yes, provide ID#: _____ Carrier Name: Aetna Better Health of Virginia
Insured: Self

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

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

C. PRESCRIBER INFORMATION

First Name: Timothy		Last Name: Adam		(Check One): ☑ M.D. ☐ D.O. ☐ N.P. ☐ P.A.	
Address: 2755 College Ave Ste. 100		City: Leesburg		State: VA	ZIP: 20176
Phone: 203-818-3060	Fax: 203-818-3061	St Lic #:	NPI #: 1321124163	DEA #:	UPIN:
Provider Email: intake@thealth.com		Office Contact Name:		Phone: 203-818-3060	

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: 600 mg IV at weeks 0, 4, 8; 360 m **Frequency:** per protocol

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

Primary ICD Code: K50.111 **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 drug be used in combination with any other biologic (e.g., Humira) or targeted synthetic drug (e.g., Olumiant, Otezla, Xeljanz)?

☑ Yes ☐ No Has the patient ever received (including current utilizers) a biologic (e.g., Humira) or targeted synthetic drug (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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For Medicare Advantage Part B:
Please Use Medicare Request Form

Patient First Name	Patient Last Name	Patient Phone	Patient DOB
Akshay	Chaudhari	570-599-6973	02/17/1987

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

Crohn's Disease (CD)

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

☑ Yes ☐ No Is the requested drug being prescribed by or in consultation with a gastroenterologist?

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

☐ Yes ☑ No Is the patient currently receiving the requested drug?

→ Please indicate loading dose at weeks 0, 4 and 8: 0, 4, 8

Please indicate maintenance dose: 360 mg SQ at week 12 and every 8 weeks frequency: 8 weeks

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

H. ACKNOWLEDGEMENT

Request Completed By *(Signature Required)*: _____ **Date:** 05 / 30 / 2023

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.