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 #: None
Insured: Akshay Chaudhari

Does patient have other coverage? ☐ Yes ☑ No
If yes, provide ID#: None Carrier Name: Aetna Better Health of Virginia
Insured: Akshay Chaudhari

Medicare: ☐ Yes ☑ No If yes, provide ID #: None **Medicaid:** ☐ Yes ☑ No If yes, provide ID #: None

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 #: None	NPI #: 1321124163	DEA #: None	UPIN: None
Provider Email: None	Office Contact Name: None	Phone: None			

Specialty *(Check one):* ☑ **Gastroenterologist** ☐ **Other**: None

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:
☐ Self-administered ☑ Physician's Office
☐ Outpatient Infusion Center Phone: None
Center Name: None
☐ Home Infusion Center Phone: None
Agency Name: None
☐ Administration code(s) (CPT): None
Address: None

Dispensing Provider/Pharmacy: *Patient Selected choice*
☑ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Other
Name: None
Address: None
Phone: None Fax: None
TIN: None PIN: None

E. PRODUCT INFORMATION

Request is for: Skyrizi (risankizumab-rzaa) Dose: Induction Phase: 600mg IV; Maint **Frequency:** Induction Phase: 0, 4, 8 weeks; Maintenance Phase

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

Primary ICD Code: K50.111 **Secondary ICD Code:** None **Other ICD Code:** None

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:
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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: 600mg IV at weeks 0, 4, 8

Please indicate maintenance dose: 360mg SQ 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.