



# Skyrizi® (risankizumab-rzaa) Medication Precertification Request

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(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 \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
☐ 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 #: _____		Does patient have other coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Group #: _____		If yes, provide ID#: _____ Carrier Name: _____	
Insured: _____		Insured: _____	
Medicare: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide ID #:		Medicaid: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide ID #:	

## C. PRESCRIBER INFORMATION

First Name:		Last Name:		(Check One): <input type="checkbox"/> M.D. <input type="checkbox"/> D.O. <input type="checkbox"/> N.P. <input type="checkbox"/> 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

<b>Place of Administration:</b> <input type="checkbox"/> Self-administered <input type="checkbox"/> Physician's Office <input type="checkbox"/> Outpatient Infusion Center Phone: _____ Center Name: _____ <input type="checkbox"/> Home Infusion Center Phone: _____ Agency Name: _____ <input type="checkbox"/> Administration code(s) (CPT): _____ Address: _____	<b>Dispensing Provider/Pharmacy:</b> <i>Patient Selected choice</i> <input type="checkbox"/> Physician's Office <input type="checkbox"/> Retail Pharmacy <input type="checkbox"/> Specialty Pharmacy <input type="checkbox"/> Other Name: _____ Address: _____ Phone: _____ Fax: _____ TIN: _____ PIN: _____
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## 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 drug be used in combination with any other biologic (e.g., Humira) or targeted synthetic drug (e.g., Olumiant, 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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Patient First Name	Patient Last Name	Patient Phone	Patient DOB
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**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: \_\_\_\_\_
- 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)?

**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.