Health Partners Medicare

***2023 PRIOR AUTHORIZATION REQUEST FORM***

Skyrizi - Medicare

**Phone: 215-991-4300** **Fax back to: 866-371-3239**

Health Partners Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

**PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.**

| **Patient Name:** | **Prescriber Name:** |
|---|---|
| Member Number: | Fax: Phone: |
| Date of Birth: | Office Contact: |
| Line of Business: □ Medicare | NPI: State Lic ID: |
| Address: | Address: |
| City, State ZIP: | City, State ZIP: |
| Primary Phone: | **Specialty/facility name (if applicable):** |

☐ REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that applying the 72 hour standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

| | |
|---|---|
| Drug Name: | |
| Strength: | |
| Directions / SIG: | |

**Please attach any pertinent medical history including labs and information for this member that may support approval.**
**Please answer the following questions and sign.**

Q1. Is the drug prescribed by or in consultation with a dermatologist, rheumatologist or gastroenterologist?

☐ Yes ☐ No

Q2. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q3. Does the patient have a confirmed diagnosis of moderately to severely active plaque psoriasis? Please attach clinical documentation.

☐ Yes ☐ No

Q4. Is there a documented history of inadequate response, intolerance or contraindication to methotrexate or UVB therapy (alone or in combination with other medications) or acitretin? Attach documentation.

☐ Yes ☐ No

Q5. Does the patient have a confirmed diagnosis of active psoriatic arthritis? Please attach clinical documentation.

☐ Yes ☐ No

Q6. Is there a documented history of inadequate response, intolerance or contraindication to at least one DMARD?

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| **Patient Name:** | **Prescriber Name:** |
|---|---|

☐ Yes ☐ No

Q7. Does the patient have a confirmed diagnosis of moderately to severely active Crohn's disease? Please attach clinical documentation.

☐ Yes ☐ No

Q8. Is there documentation of liver enzymes and bilirubin levels prior to initiating treatment?

☐ Yes ☐ No

Q9. Is there documentation of inadequate response, intolerance or contraindication to corticosteroids, methotrexate or azathioprine?

☐ Yes ☐ No

Q10. Does recent tuberculin testing show that the patient is negative for latent tuberculosis infection? Please attach documentation of recent testing.

☐ Yes ☐ No

Q11. Is there is documentation that the patient has completed treatment (or is receiving treatment) for latent tuberculosis? Please attach documentation of treatment.

☐ Yes ☐ No

Q12. Does the patient have any other active, serious infection?

☐ Yes ☐ No

Q13. Additional Information:

Prescriber Signature

Date

2023 Medicare Prior Authorization Request