Cigna®

Fax completed form to: (855) 840-1678
If this is an URGENT request, please call (800) 882-4462
(800.88.CIGNA)

Skyrizi IV
(risankizumab)

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician's Name:			*Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed.*		
Specialty:	* DEA, NPI or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* Cigna ID:	* Date of Birth:	
Office Fax:			* Patient Street Address:		
Office Street Address:			City	State	Zip
City	State	Zip	Patient Phone:		

Urgency:
☐ Standard ☐ Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)

Medication requested:
☐ Skyrizi 600mg/10ml vial ☐ other (please specify):

Dose and Quantity: Duration of therapy: J-Code:

Frequency of administration: ICD10:
Is this a new start or continuation of therapy? If your patient has already begun treatment with drug samples of Skyrizi, please choose "new start of therapy". ☐ new start of therapy ☐ continuation of therapy

Besides the drug being requested, other biologics and tsDMARDs (targeted synthetic disease-modifying antirheumatic drugs) include Actemra, Adbry, Cibinqo, Cimzia, Cosentyx, Enbrel, Entyvio, Humira, Ilumya, Infliximab (Avsola, Inflectra, Remicade, Renflexis), Kevzara, Kineret, Olumiant, Orencia, Otezla, Rinvoq, Rituximab (Riabni, Rituxan, Rituxan Hycela, Ruxience, Truxima), Siliq, Simponi Aria, Simponi, Stelara, Taltz, Tremfya, Tysabri, Xeljanz, Xeljanz XR, Zeposia. Which of the following best describes your patient's situation?
☐ The patient is NOT taking any other biologic or tsDMARD at this time, nor will they in the future. The requested drug is the only biologic or tsDMARD the patient is/will be using.
☐ The patient is currently on another biologic or tsDMARD, but this drug will be stopped and the requested drug will be started.
☐ The patient is currently on another biologic or tsDMARD, and the requested drug will be added. The patient may continue to take both drugs together.
☐ The patient is currently on BOTH the requested drug AND another biologic or tsDMARD.
☐ other/unknown

Where will this medication be obtained?
☐ Accredo Specialty Pharmacy**
☐ Hospital Outpatient
☐ Retail pharmacy
☐ Other (please specify):
☐ Home Health / Home Infusion vendor
☐ Physician's office stock (billing on a medical claim form)
***Cigna's nationally preferred specialty pharmacy*

***Medication orders can be placed with Accredo via E-prescribe - Accredo (1620 Century Center Pkwy, Memphis, TN 38134-8822 | NCPDP 4436920), Fax 888.302.1028, or Verbal 866.759.1557*

Facility and/or doctor dispensing and administering medication:
Facility Name: State: Tax ID#:
Address (City, State, Zip Code):

Where will this drug be administered?
☐ Patient's Home
☐ Hospital Outpatient
☐ Physician's Office
☐ Other (please specify):

***NOTE:** Per some Cigna plans, infusion of medication MUST occur in the least intensive, medically appropriate setting.*

Is this patient a candidate for re-direction to an alternate setting (such as alternate infusion site, physician's office, home) with assistance of a Specialty Care Options Case Manager? ☐ Yes ☐ No (provide medical necessity rationale):

Is the requested medication for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient? ☐ Yes ☐ No

Diagnosis related to use:
☐ Crohn's disease (CD) ☐ other (please specify):

Clinical Information:

Will the requested medication be used as induction therapy? ☐ Yes ☐ No

Per the information provided, is the requested dosing regimen 600 mg infused intravenously at week 0, week 4, and week 8? ☐ Yes ☐ No

(if no) Please provide clinical support for requesting this DOSE for your patient (example could include past doses tried, past medications tried, pertinent patient history).

Does your patient meet one of the following conditions?
☐ Bowel obstruction
☐ Extraintestinal manifestations (ankylosing spondylitis, pyoderma gangrenosum, erythema nodosum)
☐ History of abscess or perforation (after healing)
☐ Involvement of the upper GI tract
☐ Less than 40 years of age
☐ Perianal disease or other enterocutaneous fistula
☐ Previous Crohn's disease-related surgery (for example, ileocolonic resection to reduce the chance of Crohn's disease recurrence)
☐ Severe disease needing hospitalization
☐ Smoker
☐ Stricturing disease
☐ No or None of the above

(if no or none of the above) Has your patient already tried any other biologic for Crohn's disease, such as Cimzia, Humira, Infliximab [Avsola, Inflectra, Remicade, Renflexis], Stelara, Tysabri? ☐ Yes ☐ No

(if no) Will the requested medication be taken concurrently (at the same time) with a corticosteroid? ☐ Yes ☐ No

(if no) The covered alternatives are corticosteroids. For the alternatives tried, please include drug name and strength, date(s) taken and for how long, and what the documented results were of taking each drug, including any intolerances or adverse reactions your patient experienced. For the alternatives NOT tried, please provide details why your patient can't try that drug.

Per the information provided above, which of the following is true for your patient in regards to the covered alternatives?
☐ The patient tried one of the alternatives, but it didn't work well enough.
☐ The patient tried one of the alternatives, but they did not tolerate it.
☐ The patient cannot try one of these alternatives because of a contraindication to this drug.
☐ Other

(if other) Will the requested medication be taken concurrently (at the same time) with a conventional systemic therapy (for example, azathioprine, 6-mercaptopurine, methotrexate)? ☐ Yes ☐ No

(if no) The covered alternative is conventional systemic therapy (for example, azathioprine, 6-mercaptopurine, methotrexate). For the alternatives tried, please include drug name and strength, date(s) taken and for how long, and what the documented results were of taking each drug, including any intolerances or adverse reactions your patient experienced. For the alternatives NOT tried, please provide details why your patient can't try that drug.

Per the information provided above, which of the following is true for your patient in regards to the covered alternatives?
☐ The patient tried one of the alternatives, but it didn't work well enough.
☐ The patient tried one of the alternatives, but they did not tolerate it.
☐ The patient cannot try one of these alternatives because of a contraindication to this drug.
☐ Other

Is this drug being prescribed by, or in consultation with, a gastroenterologist? ☐ Yes ☐ No

The preferred alternative is Humira. If your patient has tried it, please provide the strength, date(s) taken and for how long, and what the documented results were of taking this drug, including any intolerances or adverse reactions your patient experienced. If your patient has NOT tried Humiria, please provide details why your patient can't try this alternative.

Per the information provided above, which of the following is true for your patient in regards to the covered alternative?
☐ The patient tried the alternative, but it didn't work well enough.
☐ The patient is able to try the alternative, but has not done so yet.
☐ The patient tried the alternative, but they did not tolerate it.
☐ The patient can't try the alternative because of a contraindication to it.
☐ Other

Additional pertinent information: Please provide clinical rationale for the use of this drug for your patient (pertinent patient history, alternatives tried, any inability to use alternatives above or standard therapy, etc). Please include drug name(s), date(s) taken and for how long, and what the documented results were of taking each drug, including any intolerances or adverse reactions your patient experienced**.**

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature:_____ **Date:**_____

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Our standard response time for prescription drug coverage requests is 5 business days. If your request is urgent, it is important that you call us to expedite the request. View our Prescription Drug List and Coverage Policies online at cigna.com.

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