STANDARD COMMERCIAL DRUG FORMULARY
PRIOR AUTHORIZATION GUIDELINES

RISANKIZUMAB-RZAA

Generic	Brand	HICL	GCN	Medi-Span	Exception/Other
RISANKIZUMAB-RZAA	SKYRIZI	45699		GPI-10 (9025057070)	

GUIDELINES FOR USE

INITIAL CRITERIA (NOTE: FOR RENEWAL CRITERIA SEE BELOW)

1. Does the patient have a diagnosis of moderate to severe plaque psoriasis (PsO) and meet **ALL** of the following criteria?
   - The patient is 18 years of age or older
   - Therapy is prescribed by or given in consultation with a dermatologist
   - The patient has psoriatic lesions involving greater than or equal to 10% of body surface area (BSA) **OR** psoriatic lesions affecting the hands, feet, genital area, or face
   - The patient had a previous trial of or contraindication to one or more forms of conventional therapies such as PUVA (Phototherapy Ultraviolet Light A), UVB (Ultraviolet Light B), topical corticosteroids, calcipotriene, acitretin, methotrexate, or cyclosporine

   If yes, **approve for a total of 6 months by HICL or GPI-10. Please enter two authorizations as follows:**
   - **FIRST APPROVAL: Approve for 1 month with a quantity limit of #1 kit (2 syringes) per 28 days.**
   - **SECOND APPROVAL: Approve for 5 months for 2 fills with a quantity limit of #1 kit (2 syringes) per 84 days (Please enter a start date of 3 WEEKS AFTER the START date of the first approval).**

   APPROVAL TEXT: Renewal for moderate to severe plaque psoriasis requires that the patient has achieved or maintained clear or minimal disease or a decrease in PASI (Psoriasis Area and Severity Index) of at least 50% or more.

   If no, do not approve.
   DENIAL TEXT: See the initial denial text at the end of the guideline.

CONTINUED ON NEXT PAGE

RISANKIZUMAB-RZAA

INITIAL CRITERIA (CONTINUED)

INITIAL DENIAL TEXT: *Some terms are already pre-defined in parenthesis. Please use these definitions if the particular text you need to use does not already have definition(s) in it.

Our guideline named **RISANKIZUMAB-RZAA (Skyrizi)** requires the following rules be met for approval:

A. You are 18 years of age or older
B. You have moderate to severe plaque psoriasis (PsO: dry, itchy skin patches with scales)
C. The medication is prescribed by or given in consultation with a dermatologist (skin doctor)
D. You have psoriatic lesions (rashes) involving greater than or equal to 10% of body surface area (BSA) OR psoriatic lesions (rashes) affecting the hands, feet, genital area, or face
E. You have previously tried one or more forms of standard therapies, unless there is a medical reason why you cannot (contraindication), such as PUVA (Phototherapy Ultraviolet Light A), UVB (Ultraviolet Light B), topical corticosteroids, calcipotriene, acitretin, methotrexate, or cyclosporine

Your doctor told us [INSERT PT SPECIFIC INFO PROVIDED]. We do not have information showing you [INSERT UNMET CRITERIA]. This is why your request is denied. Please work with your doctor to use a different medication or get us more information if it will allow us to approve this request.

RENEWAL CRITERIA

1. Does the patient have a diagnosis of moderate to severe plaque psoriasis (PsO) **AND** meet the following criterion?
   - The patient has achieved or maintained clear or minimal disease or a decrease in PASI (Psoriasis Area and Severity Index) of at least 50% or more

     If yes, **approve for 12 months by HICL or GPI-10 with a quantity limit of #1 kit (2 syringes) per 84 days for 4 fills.**

     If no, do not approve.
     DENIAL TEXT: See the renewal denial text at the end of the guideline.

CONTINUED ON NEXT PAGE

RISANKIZUMAB-RZAA

RENEWAL CRITERIA (CONTINUED)

RENEWAL DENIAL TEXT: *Some terms are already pre-defined in parenthesis. Please use these definitions if the particular text you need to use does not already have definition(s) in it.

Our guideline named **RISANKIZUMAB-RZAA (Skyrizi)** requires the following rule(s) be met for renewal:

A. You have moderate to severe plaque psoriasis (PsO: dry, itchy skin patches with scales)
B. You have achieved or maintained clear or minimal disease or a decrease in PASI (Psoriasis Area and Severity Index) of at least 50% or more

Your doctor told us [INSERT PT SPECIFIC INFO PROVIDED]. We do not have information showing you [INSERT UNMET CRITERIA]. This is why your request is denied. Please work with your doctor to use a different medication or get us more information if it will allow us to approve this request.

RATIONALE

For further information, please refer to the Prescribing Information and/or Drug Monograph for Skyrizi.

REFERENCES

- Skyrizi [Prescribing Information]. North Chicago, IL: AbbVie, Inc.; April 2019.

Library	Commercial	NSA
Yes	Yes	No

Part D Effective: N/A
Commercial Effective: 06/01/20

Created: 05/19
Client Approval: 05/20

P&T Approval: 01/20