Fax completed form to Navitus at: 855-668-8553
For questions, please call: 877-908-6023

TEXAS MEDICAID

Drug Prior Authorization
Cytokine & CAM Antagonists: risankizumab-rzaa (Skyrizi)

Request Information (required)
This request is: ☐ **Expedited* (Urgent)** ☐ **Standard (Non-Urgent)** *Expedited means the standard review time may seriously harm the member's life, health, or ability to regain maximum function.

Member Information (required)			Prescriber Information (required)		
Member Name:			Prescriber Name:		
Member Insurance ID #:			NPI # :	Specialty:	
Date of Birth:			Office Phone:		
Member Phone:			Office Fax:		
Member Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:

Please fill out the following information:
1. Medication Requested (Name): (Go to #2)

2. Quantity Requested:
(Go to #3)

3. Dose Requested (Strength):
(Go to #4)

4. Dosing Instructions:
(Go to #5)

Required Criteria

5. Provide primary diagnosis including ICD-10 code(s):
(Go to #6)

6. Please indicate the requested drug's formulary status: *(Formulary available at www.txvendordrug.com)

- ◯ Non-Preferred Drug (NPD or NAP)
  (Go to #7)
- ◯ Preferred Drug (PDL)
  (Go to #10)
- ◯ No Status, Drug is not in a Market Basket
  (Go to #10)
- ◯ N/A as this request is for a CHIP/PERINATE member
  (Go to #10)

Preferred Drug List (PDL) Criteria (required for non-preferred products)

7. Has the member failed a 30-day treatment trial with at least one (1) preferred agent in the last 180 days?

- ◯ Yes
  (Go to #10)
- ◯ No
  (Go to #8)

8. Is there a documented allergy or contraindication to preferred agents in this class?

- ◯ Yes
  (Go to #10)
- ◯ No
  (Go to #9)

9. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?

- ◯ Yes
  (Go to #10)
- ◯ No (Deny)
  (Go to #10)

Clinical Criteria (required)

10. Is the member greater than or equal to (≥) 18 years of age?

- ◯ Yes
  (Go to #11)
- ◯ No (Deny)
  (Go to #11)

11. Does the member have a diagnosis of moderately to severely active Crohn's disease (CD), moderate to severe plaque psoriasis (PS) or active psoriatic arthritis (PsA) in the last 730 days?

- ◯ Yes
  (Go to #12)
- ◯ No (Deny)
  (Go to #12)

12. Does the member have a serious active infection (including Hepatitis B virus and/or tuberculosis) in the last 180 days?

- ◯ Yes (Deny)
  (Go to #13)
- ◯ No
  (Go to #13)

13. Is the request for less than or equal to (≤) two (2) 75mg syringes or one (1) 180mg or 360mg cartridge?

- ◯ Yes (Approve - 365 days)
  (Go to #14)
- ◯ No (Deny)
  (Go to #14)

Additional Information

14. Please provide any additional information we should consider (or attach any supporting documents):
(END)

Submission Information (required)

Prescriber Signature: _____ **Date:** _____

** PLEASE FAX COMPLETED FORM TO: 855-668-8553 **

If criteria not met, submit chart documentation with form citing complex medical circumstances.
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