CHORUS COMMUNITY HEALTH PLANS

Skyrizi
Prior authorization form

If this is an urgent request, please call Together with CCHP Pharmacy Services.
Otherwise please return completed form to Together with CCHP Pharmacy Services.
Phone: 844-201-4677 or Fax: 844-2001-4675

PLEASE TYPE OR PRINT NEATLY
Incomplete responses may delay this request.

Office contact:		**Provider specialty:**	
Provider first name:		**Provider last name:**	
Provider phone #:	**Provider fax #:**	**Provider NPI #:**	
Patient name:	**Together with CCHP Member ID #:**	**Patient DOB:**	**Patient age:**
Drug requested: ☐ Brand ☐Generic	**Strength:**	**Frequency:**	**Quantity dispensed (including units):**

Generic equivalent drugs will be substituted for brand name drugs unless you specifically indicate otherwise.

☐ New medication ☐ Ongoing medication	**If ongoing, please provide start date:**	**If ongoing, did the member show improvement while on therapy?**	☐ Yes ☐ No

Diagnosis:

Place of administration:
☐ Physician's Office ☐ Hospital/Facility ☐ Patient Home ☐ Other

Please provide hospital/facility information:
Name: ______________________
Phone: ______________________
Address: ______________________
____

Please indicate how medication will be billed:
☐ Billed directly by the provider via JCODE
JCODE: ______________
☐ Billed by a pharmacy and delivered to the provider
☐ Billed by a pharmacy and delivered to the patient

Please complete all of the following sections:

Please indicate disease severity: ☐ Mild ☐ Moderate ☐ Severe

Date of most recent tuberculosis skin test:____________ Result of tuberculosis skin test: ☐ Positive ☐ Negative

Does the member currently have evidence of infection? ☐ Yes ☐ No

Is the member currently using another TNF-blocking or biologic agent in combination with Skyrizi? ☐ Yes ☐ No
If yes, please provide name of medication: ______________________

Please indicate the diagnosis on the left and complete the corresponding questions.

☐ Plaque Psoriasis	Please indicate % body surface area involvement:	Less than 5% Greater than or equal to 5%
	Does the member have plaque psoriasis on the palms, soles, head, neck or genitalia?	☐ Yes ☐ No
	Has the member tried and failed topical treatments, phototherapy or photochemotherapy?	☐ Yes ☐ No

Please be sure to complete and include the 2nd page of this form.

Skyrizi

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Patient Name:	Together with CCHP Member ID Number:	Patient DOB:

Please be sure to complete and include the 1st page of this form.

Please indicate past medication(s) tried and failed (including topical treatments):

Medication name	Start date	End date	Strength	Frequency	Reason for failure, discontinuation
Topical therapies (please list)					
Conventional non-biologic systemic therapies					
☐ Acitretin					
☐ Cyclosporine					
☐ Methotrexate					
Biologic therapies (please list)					
☐ Other (please list):					

Please provide any additional information in the space below.