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:

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

What is the indication or diagnosis?
☐ Crohn's disease (CD) ☐ other (please specify):

Clinical Information:

Will the requested medication be used in combination with a BIOLOGIC or with a targeted synthetic oral small molecule drug used for an inflammatory condition? ☐ Yes ☐ No

If Crohn's disease:

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

Has the patient tried or is currently taking corticosteroids, or are corticosteroids contraindicated in this patient? Please Note: Examples of corticosteroids are prednisone or methylprednisolone. ☐ Yes ☐ No

Has the patient tried one other conventional systemic therapy for Crohn's disease? Please Note: Examples of conventional systemic therapy for Crohn's disease include azathioprine, 6-mercaptopurine, or methotrexate. A trial of mesalamine does not count as a systemic agent for Crohn's disease. ☐ Yes ☐ No

Has the patient had a previous trial of a biologic used for Crohn's disease? Please Note: Examples of biologics used for Crohn's disease are an adalimumab product (Humira, biosimilars), Cimzia, an infliximab IV product (Remicade, biosimilars), Zymfentra, Stelara (SC or IV), or Entyvio (IV or SC). ☐ Yes ☐ No

Does the patient have enterocutaneous (perianal or abdominal) or rectovaginal fistulas? ☐ Yes ☐ No

Has the patient had an ileocolonic resection (to reduce the chance of Crohn's disease recurrence)? ☐ Yes ☐ No

Is the requested medication being prescribed by or in consultation with a gastroenterologist? ☐ Yes ☐ No

If Ulcerative colitis:

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

Has the patient had a trial of ONE systemic agent for ulcerative colitis? Please Note: Examples include 6-mercaptopurine, azathioprine, cyclosporine, tacrolimus, or a corticosteroid such as prednisone, methylprednisolone. A trial of a mesalamine product does not count as a systemic therapy for ulcerative colitis. ☐ Yes ☐ No

Has the patient tried at least one biologic other than the requested drug for ulcerative colitis? Please Note: Examples include adalimumab SC products (Humira, biosimilars), Entyvio (IV or SC), an infliximab IV product (Remicade, biosimilars), Zymfentra, Omvoh (IV or SC), Simponi (SC), and Stelara (IV or SC). A biosimilar of the requested biologic does not count. ☐ Yes ☐ No

Does the patient have pouchitis? ☐ Yes ☐ No

Has the patient tried an antibiotic, probiotic, corticosteroid enema, or mesalamine enema? Please Note: Examples of antibiotics include metronidazole and ciprofloxacin. Examples of corticosteroid enemas include hydrocortisone enema. ☐ Yes ☐ No

Is the requested medication being prescribed by or in consultation with a gastroenterologist? ☐ Yes ☐ No

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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