Health Partners Plans

HEALTH PARTNERS MEDICARE
PRIOR AUTHORIZATION REQUEST FORM

Skyrizi - Medicare

Phone: 215-991-4300 Fax back to: 866-371-3239

Health Partners Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**	
Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Line of Business: □ Medicare	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

☐ REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that applying the 72 hour standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:
Strength:
Directions / SIG:

Please attach any pertinent medical history including labs and information for this member that may support approval.
Please answer the following questions and sign.

Q1. Is the drug prescribed by or in consultation with a dermatologist?
☐ Yes ☐ No

Q2. Is the patient 18 years of age or older?
☐ Yes ☐ No

Q3. Does the patient have a confirmed diagnosis of moderately to severely active plaque psoriasis? Must attach clinical documentation that supports diagnosis and confirms severity.
☐ Yes ☐ No

Q4. Does recent tuberculin testing show that the patient is negative for latent tuberculosis infection? Must attach documentation of recent testing.
☐ Yes ☐ No

Q5. Is there is documentation that the patient has completed treatment (or is receiving treatment) for latent tuberculosis? Must attach documentation of treatment.
☐ Yes ☐ No

Q6. Does the patient have any other active, serious infection?
☐ Yes ☐ No

Q7. Is there confirmation that live vaccines will be avoided immediately prior to and during Skyrizi therapy?
☐ Yes ☐ No

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Patient Name:	**Prescriber Name:**

Q8. Is there a documented history of inadequate response, intolerance or contraindication to methotrexate or UVB therapy (alone or in combination with other medications) or Acitretin?
Must attach documentation to support methotrexate, UVB or Acitretin history.

☐ Yes ☐ No

Q9. Additional Information

Q10. Duration:

☐ 12 months

Prescriber Signature

Date

2021 Medicare Prior Authorization Request