



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:		
<b>Urgency:</b> <input type="checkbox"/> Standard <input type="checkbox"/> 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)					
<b>Medication requested:</b> <input type="checkbox"/> Skyrizi 600mg/10ml vial <input type="checkbox"/> other (please specify):  Dose and Quantity: _____ Duration of therapy: _____ J-Code: _____ Frequency of administration: _____ ICD10: _____					
<b>Where will this medication be obtained?</b> <input type="checkbox"/> Accredo Specialty Pharmacy** <input type="checkbox"/> Home Health / Home Infusion vendor <input type="checkbox"/> Hospital Outpatient <input type="checkbox"/> Physician's office stock (billing on a medical claim form) <input type="checkbox"/> Retail pharmacy <input type="checkbox"/> Other (please specify): _____ <i>**Cigna's nationally preferred specialty pharmacy</i> <i>**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</i>					
<b>Facility and/or doctor dispensing and administering medication:</b> Facility Name: _____ State: _____ Tax ID#: _____ Address (City, State, Zip Code): _____					
<b>Where will this drug be administered?</b> <input type="checkbox"/> Patient's Home <input type="checkbox"/> Physician's Office <input type="checkbox"/> Hospital Outpatient <input type="checkbox"/> Other (please specify): _____  <b>NOTE:</b> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No					
<b>What is the indication or diagnosis?</b> <input type="checkbox"/> Crohn's disease (CD) <input type="checkbox"/> 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?

Biologic (an adalimumab product [Humira, biosimilar], Bimzelx, Cimzia, Cosentyx (IV or SC), etanercept SC product [Enbrel, biosimilar], Entyvio (IV or SC), Ilumya, infliximab IV products [Remicade, biosimilar], Kevzara, Kineret, Omvoh (IV or SC), Orencia [IV or SC], a rituximab IV product [Rituxan, biosimilar], Skyrizi (SC), Siliq, Simponi [Aria or SC]), an ustekinumab product [Stelara (IV or SC), biosimilar], Taltz, a tocilizumab product [Actemra (IV or SC), biosimilar], Tremfya (IV or SC), or Zymfentra.

Targeted synthetic oral small molecule drug (such as Cibinqo, Leqselvi, Litfulo, Sotyktu, Olumiant, Otezla, Otezla XR, Rinvoq, Rinvoq LQ, Xeljanz, Xeljanz XR, Velsipity, or Zeposia.)

Conventional synthetic DMARD (such as methotrexate, leflunomide, sulfasalazine, hydroxychloroquine)

No, the requested medication will NOT be used in combination with another BIOLOGIC or targeted synthetic oral small molecule drug

**If Crohn's disease:**

Will the requested medication be used as induction therapy?

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

Is the requested medication being prescribed by or in consultation with a gastroenterologist?

Yes  No

**Additional pertinent information:**

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](http://cigna.com).*

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