Prior Authorization Form

Note: Please provide as much information as possible on this form. Missing data may cause processing delays for requested authorization(s). Attach additional sheets to this form if necessary.

Please fax the completed PA form and any additional informational sheets to Nirvanahealth at the following fax number: +1(866) 871-8565

Patient Information		Prescriber Information	
Patient Name:		Prescriber Name:	
Health Plan Name:		Prescriber Address:	
Patient Insurance Id:			
Patient Date of Birth:		Prescriber Phone:	( )
Patient Phone:		Prescriber Fax:	( )
		Prescriber Specialty:	
		Prescriber DEA:	
		Prescriber NPI:	

Medication & Medical Information	
Requested Drug(s) & Strength(s):	[ ] Skyrizi 150 mg/1.66 mL(75 mg/0.83 mL x 2) subcutaneous syringe kit [ ] Skyrizi 150 mg/mL subcutaneous pen injector [ ] Skyrizi 150 mg/mL subcutaneous syringe [ ] Skyrizi 180 mg/1.2 mL (150 mg/mL) subcutaneous wearable injector [ ] Skyrizi 360 mg/2.4 mL (150 mg/mL) subcutaneous wearable injector [ ] Skyrizi 60 mg/mL intravenous solution [ ] Skyrizi 75 mg/0.83 mL subcutaneous syringe
Requested Daily Quantity Limit – Amount:	
Requested Daily Quantity Limit – Days:	
Requested Quantity Limit Over Time – Amount:	
Requested Quantity Limit Over Time – Days:	
Requested Quantity Per Rx – Amount:	
Expected Length of Therapy:	
Directions:	
Diagnosis and Diagnosis Codes (ICD-10 Standard Codes):	
List drugs used previously to treat the same condition:	
Additional clinical information or history. Please include any relevant test results and/or medical record notes:	

Questionnaire

Q1: I, as the provider or designated representative of the provider, certify and attest that the information provided is complete and accurate and that, upon request, I shall provide any information to RxAdvance that RxAdvance determines is reasonably necessary to verify my responses. (Check only one that apply)

[ ] Yes

[ ] No

Q2: Is the member currently treated with this medication? (Check only one that apply)

[ ] Yes (please list start date of therapy (month/day/year)) _____ (*Required)

[ ] No

Q3: What is the member's diagnosis? (Check only one that apply)

[ ] Moderate to severe Plaque psoriasis (PsO)

[ ] Psoriatic arthritis (PsA)

[ ] Other (please specify the member's diagnosis and provide clinical rationale for the request) _____(*Required)

Q4: Does the member have a documentation of positive clinical response to therapy as evidenced by any one of the following: (Check only one that apply)

[ ] Reduction in the body surface area (BSA) involvement from baseline (please provide supporting document(s)) _____(*Required)

[ ] Improvement in symptoms (eg, pruritus, inflammation) from baseline (please provide supporting document(s)) _____(*Required)

[ ] Other (Please specify the member's diagnosis and provide clinical rationale for the request) _____(*Required)

Q5: Does the member have a documentation of positive clinical response to therapy as evidenced by any one of the following: (Check only one that apply)

[ ] Reduction in the total active (swollen and tender) joint count from baseline (please provide supporting document(s)) _____(*Required)

[ ] Improvement in symptoms (eg, pain, stiffness, pruritus, inflammation) from baseline (please provide supporting document (s)) _____(*Required)

[ ] Reduction in the BSA involvement from baseline (please provide supporting document(s)) _____(*Required)

[ ] Other (Please specify the member's diagnosis and provide clinical rationale for the request) _____(*Required)

Q6: What is the member's diagnosis? (Check only one that apply)

[ ] Moderate to severe Plaque psoriasis (PsO)

[ ] Psoriatic arthritis (PsA)

[ ] Other (please specify the member's diagnosis and provide clinical rationale for the request) _____(*Required)

Q7: Member's diagnosis is supported by any one of the following: (Check only one that apply)

[ ] At least 3% body surface area (BSA) involvement

[ ] Severe scalp psoriasis

[ ] Palmoplantar (i.e., palms, soles), facial, or genital involvement

[ ] Other (please provide clinical rationale for the request) _____ (*Required)

Q8: Has the member had an inadequate response, contraindication(s) or have intolerance to at least one of the following topical therapies: corticosteroids (e.g., betamethasone, clobetasol), vitamin D analogs (e.g., calcitriol, calcipotriene), tazarotene, calcineurin inhibitors (e.g., tacrolimus, pimecrolimus), anthralin or coal tar, when used for at least 4 weeks? (Check only one that apply)

[ ] Yes (please specify at least one drug name(s), corresponding contraindication(s) or intolerance experienced and the start and end date(s) of therapy (month/year)) _____(*Required)

[ ] No (please provide medical justification for the request) _____ (*Required)

Q9: Is the reqeusted medication prescribed by or in consultation with a dermatologist? (Check only one that apply)

[ ] Yes

[ ] No (please provide medical justification for the request) _____ (*Required)

Q10: Member's diagnosis is supported by any one of the following: (Check only one that apply)

[ ] Actively inflamed joints

[ ] Dactylitis

[ ] Enthesitis

[ ] Axial disease

[ ] Active skin and/or nail involvement.

[ ] Other (please provide clinical rationale for the request) _____ (*Required)

Q11: Is the reqeusted medication prescribed by or in consultation with a dermatologist or rheumatologist? (Check only one that apply)

[ ] Yes (please specify prescriber specialty)

[ ] No (please provide clinical rationale for the request) _____ (*Required)

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, Insurer, Medical Group or its designated representatives may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.	
Signature of Prescriber or Authorized Representative:	Date:
Print Authorized Representative Name:	