Blue Cross Blue Shield Blue Care Network of Michigan

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Blue Cross Medicare Plus Blue℠ PPO and BCN Advantage℠ Medication Authorization Request Form SKYRIZI™ (risankizumab-rzaa) J3590

The most efficient way to request authorization is to use the NovoLogix® system. To access NovoLogix, visit bcbsm.com/providers and log in to Provider Secured Services. Click the link for Medical Prior Authorization. As an alternative, you can use this form to request authorization. Complete this form and fax to 1-866-392-6465. If you have any questions regarding this process, contact the Pharmacy Clinical Help Desk at 1-800-437-3803.

PATIENT INFORMATION	PHYSICIAN INFORMATION
Name	**Name**
ID Number	**Specialty**
Date of birth ☐Male ☐Female	**Address**
Diagnosis (include ICD-10)	**City /State/Zip**
Drug Name	**Phone:** ( ) - **Fax:** ( ) -
Dose and Quantity	**NPI**
Directions	**Contact Person**
Date of Services	**Contact Person's Phone / Ext.**

STEP 1: DISEASE STATE INFORMATION

1. Is this request for self or office-administration? ☐ Self-administration ☐ Office ☐ Other. Please specify_____

2. Initial or Continuation request? ☐ Initial ☐ Continuation, please specify the date of last injection _____

3. What is the diagnosis for this medication?
   - ☐ Moderate to Severe Plaque Psoriasis
   - ☐ Other. Please list indication_____

4. Which of the following therapies has the patient tried and failed?
   - ☐ Topical steroids
   - ☐ Phototherapy or Photochemotherapy
   - ☐ Oral systemic agent for psoriasis (ie. methotrexate, acitretin, cyclosporine)
   - ☐ Other. Please Specify medications used _____

5. For continuation: How has the patient responded to therapy?
   - ☐ Achieved a PASI 75 response
   - ☐ Achieved greater than 50% reduction in BSA covered by plaque psoriasis compared to baseline
   - ☐ Other. Please specify response _____

6. Please attach any chart notes or additional documentation and submit to plan. ***(Required)***

Coverage won't be provided if the prescribing physician's signature and date aren't reflected on this document.

☐ Request for expedited review: I certify that applying the standard review time frame may seriously jeopardize the life or health of the member or the member's ability to regain maximum function

Physician's Name **Physician's Signature** **Date**

Step 2: Checklist	☐ Form Completely Filled Out ☐ Attached Chart Notes	☐ Concurrent Medical Problems ☐ Prior Therapies
Step 3: Submit	**Fax the completed form to 1-866-392-6465**	