UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

Program Number	2021 P 1293-3
Program	Prior Authorization/Notification
Medication	Skyrizi™ (risankizumab-rzaa) injection
P&T Approval Date	9/2019, 9/2020, 9/2021
Effective Date	12/1/2021; Oxford only: 12/1/2021

1. **Background:**

   Skyrizi is an interleukin-23 antagonist indicated for the treatment of moderate to severe plaque psoriasis in adults who are candidates for systemic therapy or phototherapy.

2. **Coverage Criteria:**

A. Plaque Psoriasis

1. Initial Authorization

a. Skyrizi will be approved based on **both** of the following criteria:

(1) Diagnosis of moderate to severe plaque psoriasis

-AND-

(2) Patient is not receiving Skyrizi in combination with **any** of the following:

(a) Biologic DMARD [e.g., Enbrel (etanercept), Humira (adalimumab), Cimzia (certolizumab), Simponi (golimumab)]
(b) Janus kinase inhibitor [e.g., Xeljanz/XR (tofacitinib), Olumiant (baricitinib)]
(c) Phosphodiesterase 4 (PDE4) inhibitor [e.g. Otezla (apremilast)]

Authorization will be issued for 12 months.

2. Reauthorization

a. Skyrizi will be approved based on **both** of the following criteria:

(1) Documentation of positive clinical response to Skyrizi therapy

-AND-

(2) Patient is not receiving Skyrizi in combination with **any** of the following:

(a) Biologic DMARD [e.g., Enbrel (etanercept), Humira (adalimumab), Cimzia (certolizumab), Simponi (golimumab)]
(b) Janus kinase inhibitor [e.g., Xeljanz/XR (tofacitinib), Olumiant (baricitinib)]
(c) Phosphodiesterase 4 (PDE4) inhibitor [e.g. Otezla (apremilast)]

Authorization will be issued for 12 months.

3. Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits, Medical Necessity, and/or Step Therapy may be in place.

4. References:

1. Skyrizi [package insert]. North Chicago, IL: AbbVie Inc.; April 2021.

Program	Prior Authorization/Notification – Skyrizi™ (risankizumab-rzaa)
Change Control	
9/2019	New program
9/2020	Annual review. Changed reauthorization duration to 12 months. Updated reference.
9/2021	Annual review with no changes to coverage criteria. Updated reference.