

**Texas Prior Authorization Program
Clinical Criteria**

Drug/Drug Class**Cytokine and CAM Antagonists**

This criteria was recommended for review by the Texas Medicaid Vendor Drug Program to ensure appropriate and safe utilization

Clinical Criteria Information Included in this Document**Syrizi (Risankizumab-rzaa)**

- **Drugs requiring prior authorization:** the list of drugs requiring prior authorization for this clinical criteria
- **Prior authorization criteria logic:** a description of how the prior authorization request will be evaluated against the clinical criteria rules
- **Logic diagram:** a visual depiction of the clinical criteria logic
- **Supporting tables:** a collection of information associated with the steps within the criteria (diagnosis codes, procedure codes, and therapy codes)
- **References:** clinical publications and sources relevant to this clinical criteria

Note: Click the hyperlink to navigate directly to that section.

Revision Notes

Initial publication



Skyrizi (Risankizumab-rzaa)

Drugs Requiring Prior Authorization

Skyrizi	
Label Name	GCN
SKYRIZI 75 MG/0.83 ML SYRINGE	46213
SKYRIZI 150 MG DOSE KIT - 2 SYRN	46215



Skyrizi (Risankizumab-rzaa)

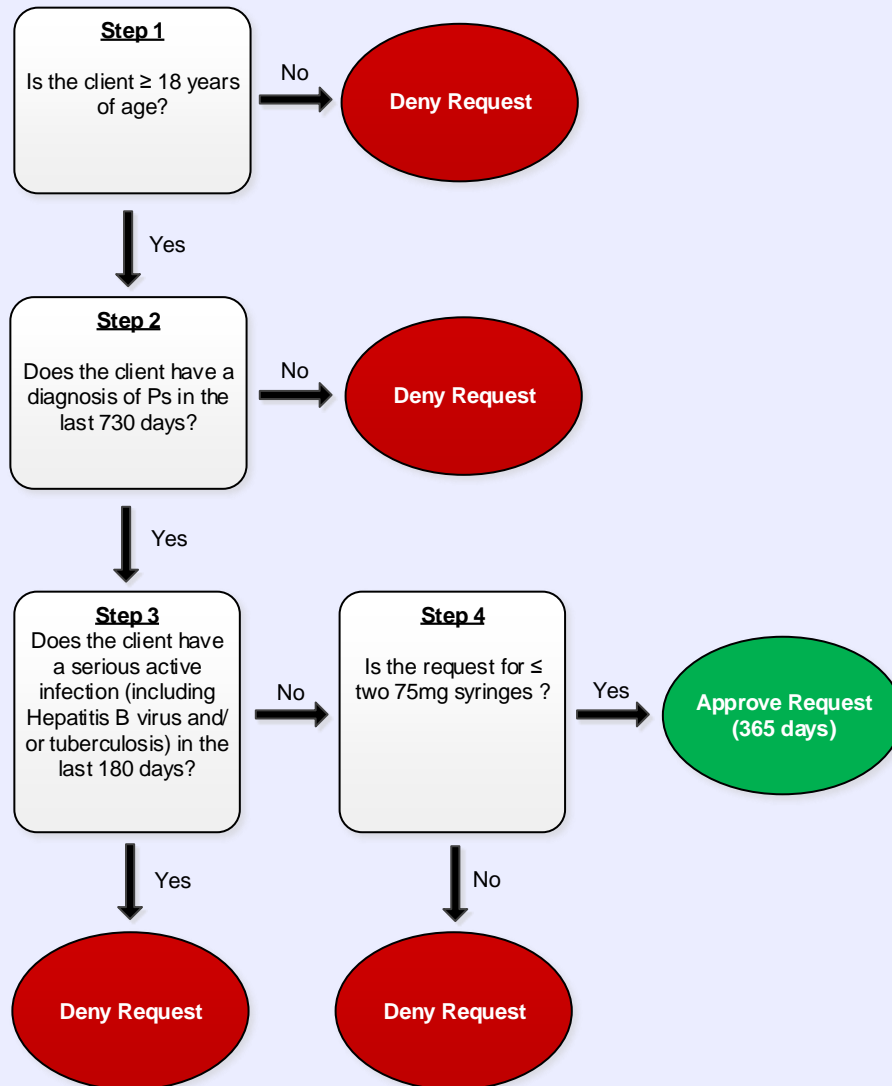
Clinical Criteria Logic

1. Is the client greater than or equal to (\geq) 18 years of age?
 Yes - Go to #2
 No - Deny
2. Does the client have a diagnosis of **moderate to severe plaque psoriasis** in the last 730 days?
 Yes - Go to #3
 No - Deny
3. Does the client have a **serious active infection** (including Hepatitis B virus and/or tuberculosis) in the last 180 days?
 Yes - Deny
 No - Go to #4
4. Is the request for less than or equal to (\leq) two 75mg syringes?
 Yes - Approve (365 days)
 No - Deny



Skyrizi (Risankizumab-rzaa)

Clinical Criteria Logic Diagram





Skyrizi (Risankizumab-rzaa)

Clinical Criteria Supporting Tables

Step 2 (diagnosis of plaque psoriasis) Required quantity: 1 Look back timeframe: 730 days	
ICD-10 Code	Description
L400	PSORIASIS VULGARIS
L401	GENERALIZED PUSTULAR PSORIASIS
L402	ACRODERMATITIS CONTINUA
L403	PUSTULOSIS PALMARIS ET PLANTARIS
L404	GUTTATE PSORIASIS
L408	OTHER PSORIASIS
L409	PSORIASIS, UNSPECIFIED

Step 3 (serious active infection) Required quantity: 1 Look back timeframe: 180 days	
ICD-10 Code	Description
B160	ACUTE HEPATITIS B WITH DELTA-AGENT WITH HEPATIC COMA
B161	ACUTE HEPATITIS B WITH DELTA-AGENT WITHOUT HEPATIC COMA
B162	ACUTE HEPATITIS B WITHOUT DELTA-AGENT WITH HEPATIC COMA
B169	ACUTE HEPATITIS B WITHOUT DELTA-AGENT AND WITHOUT HEPATIC COMA
B180	CHRONIC VIRAL HEPATITIS B WITH DELTA-AGENT
B181	CHRONIC VIRAL HEPATITIS B WITHOUT DELTA-AGENT
B1910	UNSPECIFIED VIRAL HEPATITIS B WITHOUT HEPATIC COMA
B1911	UNSPECIFIED VIRAL HEPATITIS B WITH HEPATIC COMA
A150	TUBERCULOSIS OF LUNG
A154	TUBERCULOSIS OF INTRATHORACIC LYMPH NODES
A155	TUBERCULOSIS OF LARYNX, TRACHEA AND BRONCHUS
A156	TUBERCULOUS PLEURISY
A157	PRIMARY RESPIRATORY TUBERCULOSIS
A158	OTHER RESPIRATORY TUBERCULOSIS
A159	RESPIRATORY TUBERCULOSIS UNSPECIFIED
B440	INVASIVE PULMONARY ASPERGILLOSIS
B441	OTHER PULMONARY ASPERGILLOSIS

Step 3 (serious active infection) Required quantity: 1 Look back timeframe: 180 days	
ICD-10 Code	Description
B447	DISSEMINATED ASPERGILLOSIS
B449	ASPERGILLOSIS, UNSPECIFIED
B59	PNEUMOCYSTOSIS



Cytokine and CAM Antagonists

Clinical Criteria References

1. Clinical Pharmacology [online database]. Tampa, FL: Elsevier / Gold Standard, Inc. 2019. Available at <http://www.clinicalpharmacology.com>. Accessed on May 24, 2019.
2. 2019 ICD-10-CM Diagnosis Codes. Available at <http://www.icd10data.com/>. Accessed on May 24, 2019.
3. Skyrizi Prescribing Information. AbbVie Inc. North Chicago, IL. April 2019.

Publication History

The Publication History records the publication iterations and revisions to this document. Notes for the *most current revision* are also provided in the **Revision Notes** on the first page of this document.

Publication Date	Notes
07/26/2019	Initial publication