Skyrizi IV *(risankizumab-rzaa)*

PA Criteria	Criteria Details
Covered Uses (FDA approved indication)	Skyrizi is an IL-23 antagonist indicated for multiple inflammatory conditions including moderate to severe active Crohn's disease (CD) and moderate to severely active ulcerative colitis (UC).
Exclusion Criteria	Must not be used in combination with other biologic drugs, Otezla, or Janus Kinase Inhibitor (JAKis).
Required Medical Information	Medical records supporting the request must be provided, including documentation of prior therapies and responses to treatment.
Age Restriction	None.
Prescriber Restrictions	Prescriber is a specialist or has consulted with a specialist for the condition being treated.
Coverage Duration	Three IV induction will be approved. Subsequent maintenance doses must be approved under the pharmacy benefit.
Other Criteria/Information	Refer to the Gold Coast Health Plan Medicare Part B Reference and Summary of Evidence document.

HCPCS	Description	Billing Units/How Supplied
J2327	Skyrizi IV (risankizumab-rzaa) 600mg/10ml vial	**Billing unit: 1 mg** 600mg/10 mL SDV

STATUS	DATE REVISED	REVIEW DATE	APPROVED/REVIEWED BY	EFFECTIVE DATE
Created	3/26/2025	3/26/2025	Dawn Shojai, PharmD, Senior Pharmacy Benefit Consultant (PSG)	N/A
Approved	N/A	5/15/2025	Pharmacy & Therapeutics (P&T) Committee	5/15/2025