

**NC Medicaid
Outpatient Pharmacy
Prior Approval Criteria
Skyrizi
Systemic Immunomodulators**

**Effective Date: December 9, 2019
Amended Date: August 12, 2026**

Therapeutic Class Code: L1A
Therapeutic Class Description: Immunomodulatory Agents

Medication
Skyrizi pen or syringe

Eligible Beneficiaries

NC Medicaid (Medicaid) beneficiaries shall be enrolled on the date of service and may have service restrictions due to their eligibility category that would make them ineligible for this service.

EPSDT Special Provision: Exception to Policy Limitations for Beneficiaries under 21 Years of Age

42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid beneficiaries under 21 years of age **if** the service is **medically necessary health care** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination (includes any evaluation by a physician or other licensed clinician). This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his/her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems. Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the beneficiary's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the beneficiary's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product, or procedure

- a. that is unsafe, ineffective, or experimental/investigational.
- b. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and/or other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure meets all EPSDT criteria, including to correct or improve or maintain the beneficiary's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT and Prior Approval Requirements

If the service, product, or procedure requires prior approval, the fact that the beneficiary is under 21 years of age does **NOT** eliminate the requirement for prior approval.

IMPORTANT ADDITIONAL INFORMATION about EPSDT and prior approval is found in the NCTracks Provider Claims and Billing Assistance Guide, and on the EPSDT provider page. The Web addresses are specified 08.12.2026

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below.

NCTracks Provider Claims and Billing Assistance Guide:

<https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html>

EPSDT provider page: <https://medicaid.ncdhhs.gov/medicaid/get-started/find-programs-and-services-right-you/medicaid-benefit-children-and-adolescents>

Criteria for approval

1. Plaque psoriasis (adult):

- Beneficiary has a documented definitive diagnosis of moderate-to-severe Chronic Plaque Psoriasis
AND
- Beneficiary is 18 years of age or older.
AND
- Beneficiary is not on another biologic immunomodulator.
AND
- Beneficiary has been considered and screened for the presence of latent tuberculosis infection
AND
- Beneficiary has been tested with Hep B SAG and Core Ab.
AND
- Beneficiary has body surface area (BSA) involvement of at least 3%.
OR
- Beneficiary has involvement of the palms, soles, head and neck, or genitalia, causing disruption in normal daily activities and/or employment.
AND
- Beneficiary has failed to respond to, or has been unable to tolerate phototherapy and **ONE** of the following medications or beneficiary has contraindications to these treatments:
 - Soriatane (acitretin)
 - Methotrexate
 - Cyclosporine

2. Psoriatic arthritis (Adult):

- Beneficiary has a documented definitive diagnosis of Psoriatic Arthritis.
AND
- Beneficiary is 18 years of age or older
AND
- Beneficiary is not on another biologic immunomodulator
AND
- Beneficiary has been considered and screened for the presence of latent tuberculosis infection
AND
- Beneficiary has been tested with Hep B SAG and Core Ab
AND
- Beneficiary has a documented inadequate response or inability to take methotrexate.

3. Ulcerative colitis (Adult):

- Beneficiary has a diagnosis of ulcerative colitis.
AND

08.12.2026

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- Beneficiary is 18 years of age or older
AND
- Beneficiary is not on another biologic immunomodulator.
AND
- Beneficiary has been considered and screened for the presence of latent tuberculosis infection.
AND
- Beneficiary has been tested with Hep B SAG and Core Ab.

4. Crohn's Disease (Adult):

- Beneficiary has a diagnosis of moderate to severe Crohn's Disease.
AND
- Beneficiary is 18 years of age or older.
AND
- Beneficiary is not on another biologic immunomodulator.
AND
- Beneficiary has been considered and screened for the presence of latent tuberculosis infection.
AND
- Beneficiary has been tested with Hep B SAG and Core Ab.

Reauthorization Criteria

Documentation of positive clinical response to therapy

Beneficiary is not using the requested medication concomitantly with any other biologic medications for the same indication.

Procedures

- Approve for up to 12 months.
- Coverage of one injectable immunomodulator at a time.
- Preferred Drug List (PDL) criteria also apply if requested medication is on the PDL. (ex. try and fail preferred(s) first or a clinical reason the preferred(s) cannot be tried or other criteria as noted on the PDL).

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References

1. AbbVie, Inc., Skyrizi Prescribing Information. North Chicago, IL: April 2021.Updated January 2022. Updated May 2025.

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Criteria Change Log

12/09/2019	Criteria effective date
01/02/2025	Separated out criteria by individual agents Add Psoriatic Arthritis for Skyrizi and add coverage for Ulcerative Colitis
08/12/2026	Add diagnosis of Crohn's Disease (adult) and continuation criteria. Add PDL reference and remove trial and failure of specific preferreds.