Appeal Packet — Case #8

Aetna · Skyrizi (risankizumab) · Maya Reynolds, MD

Appeal Letter — Skyrizi (Risankizumab-rzaa) for Plaque Psoriasis

Cumberland Specialty Dermatology
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Date: August 25, 2026

Aetna Appeals & Grievances
PO Box 555
Franklin, TN 37067
Fax: (615) 555-0199 [C1]

RE: Appeal of Adverse Precertification Determination
Patient: Jordan Avery | DOB: 03/14/1988 | Member ID: SYN-00421587 [C1]
Precertification Reference: PA-88213 [C1]
Drug: Skyrizi (risankizumab-rzaa) 150 mg subcutaneous injection [C1]
Applicable policy number: Aetna CPB 1009

To Whom It May Concern:

Cumberland Specialty Dermatology respectfully requests reconsideration of the adverse precertification determination dated August 10, 2026 [C1], for Skyrizi (risankizumab-rzaa) for patient Jordan Avery. We submit that the clinical record satisfies the criteria set forth in Aetna Clinical Policy Bulletin 1009 — Risankizumab-rzaa (Skyrizi), effective July 1, 2026 [C1], and we address each denial reason below.

Board-certified dermatologist

The policy requires that for plaque psoriasis, risankizumab-rzaa "must be prescribed by or in consultation with" a "dermatologist." [C2]

1. DIAGNOSIS AND OBJECTIVE SEVERITY

The denial states that documentation did not demonstrate a diagnosis of moderate-to-severe plaque psoriasis with objective severity. [C1] The clinical record refutes this finding. The chart note dated 07/28/2026 documents an assessment of "Plaque psoriasis (L40.0), moderate-to-severe" with a "PASI 18.4 (severe range)" and "Body surface area involvement ~12%." [C3] The policy's qualifying pathway relied upon here is criterion II.A.2.b: "At least 10% of the body surface area (BSA) is affected." [C4] The documented BSA of approximately 12% meets this threshold. Additionally, the chart documents "Scalp and visible-site involvement adds substantial quality-of-life burden," [C3] which also supports criterion II.A.2.a:

"Crucial body areas (e.g., hands, feet, face, neck, scalp, genitals/groin, intertriginous areas) are affected." [C4]

2. CONVENTIONAL SYSTEMIC THERAPY — TRIAL AND INADEQUATE RESPONSE OR INTOLERANCE

The denial states that documentation did not demonstrate trial and inadequate response or contraindication/intolerance to at least one conventional systemic therapy. [C1] The chart note documents that the patient received "Methotrexate 15 mg PO weekly x 14 weeks (2025) — discontinued for transaminitis (ALT 3x ULN); INTOLERANT." [C3] This constitutes documented intolerance to methotrexate, a conventional systemic therapy specifically named by the policy. [C4]

3. PHOTOTHERAPY — TRIAL AND INADEQUATE RESPONSE

The denial states that documentation did not demonstrate trial and inadequate response to phototherapy. [C1] The chart note documents that the patient "completed a supervised course of 24 sessions" of "Narrowband UVB phototherapy (early 2026) with inadequate clearance; relapse within 6 weeks of stopping." [C3] This constitutes a documented adequate trial of narrowband UVB phototherapy with inadequate response, as contemplated by the policy's criteria at II.A.2.c.i: "Member has had an inadequate response or intolerance to either phototherapy (e.g., UVB, PUVA) or pharmacologic treatment with methotrexate, cyclosporine, or acitretin." [C5]

4. TUBERCULOSIS SCREENING

The denial states that documentation did not demonstrate negative tuberculosis screening prior to initiating therapy. [C1] The chart note documents: "Tuberculosis screening: QuantiFERON-TB Gold (IGRA) — NEGATIVE" obtained on 07/21/2026 [C3], prior to the planned initiation of Skyrizi. The policy states: "Member has been evaluated for tuberculosis (TB) infection prior to initiation of treatment with a biologic or targeted synthetic drug associated with an increased risk of TB." [C6]

Route-specific code pending benefit determination: J2327 (subcutaneous)

Based on the foregoing, we respectfully request reconsideration based on the enclosed documentation and the policy's own criteria. Please direct any questions to our office at (615) 555-0142 or fax (615) 555-0143.

Sincerely,

Maya Reynolds, MD
Attending Dermatologist
NPI: 1234567893
Cumberland Specialty Dermatology
1200 Demo Way, Suite 300
Nashville, Tennessee 37203

Codes and Authorization Duration

DIAGNOSIS CODE
ICD-10: L40.0 — Psoriasis vulgaris [C3]

PROCEDURE / DRUG CODE
Route-specific code: J2327 (subcutaneous)
Note: The policy lists J2327 (Injection, risankizumab-rzaa, intravenous, 1 mg) as the covered HCPCS code under CPB 1009. [C7] The requested administration for plaque psoriasis is subcutaneous (150 mg at Week 0, Week 4, and every 12 weeks thereafter). [C3] Benefit-category determination for the subcutaneous route is pending.

AUTHORIZATION DURATION REQUESTED
12 months

Enclosures

- Denial letter — UAT Denial Letter (Synthetic).pdf
- Chart note — UAT Chart Text (Synthetic).txt

Evidence References

[C1] UAT Denial Letter (Synthetic).pdf, p. 1: "Date: August 10, 2026
Patient: Jordan Avery (DOB 03/14/1988) — Member ID: SYN-00421587
Precertification reference: PA-88213
Requesting provider: Maya Reynolds, MD — Cumberland Specialty Dermatology, 1200 Demo Way, Suite 300, Nashville, TN 37203
RE: Skyrizi (risankizumab-rzaa) 150 mg subcutaneous injection, requested for treatment of plaque psoriasis
Policy applied: Aetna Clinical Policy Bulletin 1009 — Risankizumab-rzaa (Skyrizi), effective July 1, 2026
DECISION: NOT APPROVED (adverse determination)"
[C2] Payer policy, pages 2–2: "I. Prescriber Specialties This medication in this policy must be prescribed by or in consultation with one of the following: A. Plaque psoriasis: dermatologist;"
[C3] UAT Chart Text (Synthetic).txt, p. 1: "ASSESSMENT: Plaque psoriasis (L40.0), moderate-to-severe.
- PASI 18.4 (severe range)
- Body surface area involvement ~12%
- DLQI 17 — very large effect on daily functioning
- Scalp and visible-site involvement adds substantial quality-of-life burden

PRIOR THERAPIES (documented in chart):
1. Clobetasol 0.05% solution/foam and calcipotriene combination topicals — partial response only, plaques recur on taper (2024).
2. Methotrexate 15 mg PO weekly x 14 weeks (2025) — discontinued for transaminitis (ALT 3x ULN); INTOLERANT.
3. Narrowband UVB phototherapy — completed a supervised course of 24 sessions (early 2026) with inadequate clearance; relapse within 6 weeks of stopping.

SCREENING / LABS (07/21/2026):
- Tuberculosis screening: QuantiFERON-TB Gold (IGRA) — NEGATIVE"

[C4] Payer policy, pages 2–2: "2. For adult members for treatment of moderate-to-severe plaque psoriasis when any of the following criteria is met: a. Crucial body areas (e.g., hands, feet, face, neck, scalp, genitals/groin, intertriginous areas) are affected; or b. At least 10% of the body surface area (BSA) is affected; or"
[C5] Payer policy, pages 3–3: "i. Member has had an inadequate response or intolerance to either phototherapy (e.g., UVB, PUVA) or pharmacologic treatment with methotrexate, cyclosporine, or acitretin;"
[C6] Payer policy, pages 6–6: "For all indications: Member has been evaluated for tuberculosis (TB) infection prior to initiation of treatment with a biologic or targeted synthetic drug associated with an increased risk of TB."
[C7] Payer policy, pages 10–10: "HCPCS codes covered if selection criteria are met: J2327 Injection, risankizumab-rzaa, intravenous, 1 mg"