PriorityHealth

Pharmacy Prior Authorization Form

For Prior Authorization, please fax to: 877 974-4411 toll free, or 616 942-8206

This form applies to: ☒ **Commercial (Traditional)** ☒ **Commercial (Individual/Optimized)** ☐ **Medicaid**

This request is: ☐ **Urgent** (life threatening) ☐ **Non-Urgent** (standard review)

Urgent means the standard review time may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

Taltz® (ixekizumab)

Member

Last Name: _____ First Name: _____

ID #: _____ DOB: _____ Gender: _____

Primary Care Physician: _____

Requesting Provider: _____ Prov. Phone: _____ Prov. Fax: _____

Provider Address: _____

Provider NPI: _____ Contact Name: _____

Provider Signature: _____ Date: _____

Product and Billing Information

☐ New request ☐ Continuation request

Drug product: ☐ Taltz 80 mg/ml Autoinjector ☐ Taltz 80 mg/ml syringe

Start date (or date of next dose): _____

Date of last dose (if applicable): _____

Dose: _____

Frequency: _____

TALTZ COVERAGE POLICY

- Before Taltz is covered, the patient must meet all of the General Criteria for Taltz and all of the Specific Criteria for the treatment diagnosis. If these criteria are not met, the prescriber must provide an explanation of why an exception to the criteria is necessary.
- Coverage for a diagnosis not listed below will be considered on a case by case basis. Please provide rationale for use and all pertinent patient information.
- Taltz will not be covered in combination with another biologic drug.
- Please provide rationale when requesting any dose or dosing interval not listed in the FDA label.

Criteria

General Initiation Criteria for ALL Diagnoses:

a) Patient has evidence of a negative TB test result in the past 12 months (or TB is adequately managed); AND

b) Prescriber is a specialist or has consulted with a specialist for the disease being treated.

Specific Initiation Criteria for Individual Diagnoses:

1) Plaque Psoriasis
   a) Patient has tried ALL of the following for a period of at least 3 months:
      a. One topical agent
      b. One non-biologic systemic agent (e.g., methotrexate [MTX], cyclosporine, acitretin)
      c. Phototherapy
      d. At least TWO of the following: Cosentyx, Humira, Otezla, or Stelara for a period of at least 3 months *each*

All fields must be complete and legible for review. Your office will receive a response via fax.

Updated 12/2018
Last reviewed 01/2019

2) Psoriatic Arthritis
   a) Patient has tried at least ONE conventional systemic DMARD (such as methotrexate, leflunomide, sulfasalazine, or azathioprine) for a period of at least 3 months, AND
   b) Patient has tried at least TWO of the following: Cosentyx, Enbrel, Humira, Xeljanz/XR, or Stelara, each for a period of at least 3 months.

Note: Authorization for indications, dosing, or a route of administration not approved by the Food and Drug Administration (FDA) or recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, U.S. Pharmacopeia, and also Clinical Pharmacology for oncology indications only) require supporting evidence for coverage. Please provide two published peer-reviewed literature articles supporting the appropriateness of the drug, the dosing of the drug, or the route of administration to be used for the identified indication.

Priority Health Precertification Documentation

A. What condition is this drug being requested for?

- ☐ Plaque psoriasis
- ☐ Psoriatic arthritis
- ☐ Other – the patient's condition is: _____

Rationale for use: _____

B. Which of the following has the patient had a documented therapeutic trial with?

- ☐ Methotrexate Dates of therapy: _____
- ☐ Cyclosporine Dates of therapy: _____
- ☐ Acitretin Dates of therapy: _____
- ☐ Leflunomide Dates of therapy: _____
- ☐ Sulfasalazine Dates of therapy: _____
- ☐ Azathioprine Dates of therapy: _____
- ☐ Cosentyx Dates of therapy: _____
- ☐ Humira Dates of therapy: _____
- ☐ Otezla Dates of therapy: _____
- ☐ Xeljanz/XR Dates of therapy: _____
- ☐ Stelara Dates of therapy: _____
- ☐ Other Drug: _____ Dates of therapy: _____

C. Has the patient had a negative TB test result in the past 12 months?

- ☐ Yes Date: _____
- ☐ No, rationale for use: _____

D. Does the patient have moderate to severe heart failure?

- ☐ Yes Date: _____
- ☐ No, rationale for use: _____

E. Will the patient be receiving other biologic therapy in combination with Taltz?

☐ No ☐ Yes, rationale for use: _____

The following questions are required for **plaque psoriasis** only**:**

F. Has the patient had a trial with one or more topical agents for a period of at least 3 months?

- ☐ Yes
- ☐ No – rationale for use: _____

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G. Has the patient had a trial with phototherapy for a period of at least 3 months?

- ☐ Yes, UVA
- ☐ Yes, UVB
- ☐ No – rationale for use: _____

H. Has the patient had a trial with one or more non-biologic systemic agents for a period of at least 3 months?

- ☐ No – rationale for use: _____
- ☐ Yes – Please mark the agent(s) tried and failed above.

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Updated 12/2018
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