pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

TALTZ (ixekizumab) [non-preferred] PRIOR AUTHORIZATION FORM

Cytokine and CAM Antagonists and **Quantity Limits/Daily Dose Limits** prior authorization guidelines are accessible on the DHS Pharmacy Services website at http://www.dhs.pa.gov/provider/pharmacyservices/index.htm.

PRIOR AUTHORIZATION REQUEST INFORMATION		PRESCRIBER INFORMATION	
☐New request ☐Renewal request	# of pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		State license #:	
LTC facility contact/phone:		NPI:	MA Provider ID#:
BENEFICIARY INFORMATION		Street address:	
Beneficiary name:		Suite #:	City/State/Zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Product requested: ☐Taltz 80 mg prefilled auto-injector ☐Taltz 80 mg prefilled syringe ☐Taltz _____

Dose/directions:	Quantity:	Refills:
Diagnosis *(submit documentation)*:	Dx code (*required*):	

Specialty Pharmacy Drug Program: Which specialty pharmacy will be used? ☐Diplomat Specialty ☐Walgreen's Specialty

Initial request – complete questions applicable to beneficiary's diagnosis

1. ***All diagnoses:*** Check all that apply to the beneficiary and *submit documentation for each*.
   ☐vaccinated for hepatitis B ☐screened for hepatitis B (surface antigen & core antibody) ☐has been using Taltz in the past 90 days
   ☐screened for tuberculosis ☐up-to-date with all age-appropriate immunizations

2. ***Plaque psoriasis:*** Does either of the following apply to the beneficiary's psoriasis? *Check option that applies.* ☐at least 5% of the body surface area (BSA) is affected ☐< 5% of the BSA is affected, but affected areas include critical areas of the body (face, palms, soles of feet, and/or genitals)	☐Yes ☐No	*Submit documentation.*
3. ***Plaque psoriasis:*** Does the beneficiary have a history of trial and failure, contraindication, or intolerance to the following? *Check all that apply*. ☐3 months of PUVA ☐acitretin ☐methotrexate ☐3 months of UVB light ☐cyclosporine ☐other: _____	☐Yes ☐No	*Submit documentation of therapies tried and failed, contraindications, or intolerances.*
4. ***Plaque psoriasis*:** Does the beneficiary have a history of trial and failure, contraindication, or intolerance of the preferred agents? *Check all that apply.* ☐Cosentyx ☐Humira	☐Yes ☐No	*Submit documentation of all medications tried and outcomes.*
5. ***Psoriatic arthritis***: Does the beneficiary have a history of trial and failure, contraindication, or intolerance of the following? ☐four-week trial each of at least 2 different NSAIDs ☐eight-week trial of methotrexate or other DMARD *(does not apply to axial disease)*	☐Yes ☐No	*Submit documentation of all medications tried and outcomes.*
6. ***Psoriatic arthritis*:** Does the beneficiary have a history of trial and failure, contraindication, or intolerance of the preferred agents? *Check all that apply.* ☐Cosentyx ☐Humira ☐Xeljanz	☐Yes ☐No	*Submit documentation of all medications tried and outcomes.*

7. ***For a diagnosis other than the approved indication(s),*** submit documentation supporting the use of Taltz for the beneficiary's diagnosis & other treatments tried.

Renewal request

1. Since starting Taltz, did the beneficiary experience a positive clinical response and/or improved level of functioning?	☐Yes ☐No	*Submit documentation of clinical response.*

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	**Date**: