Taltz (ixekizumab)
Prior Authorization Request Form

Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

MEMBER'S LAST NAME: _____ **MEMBER'S FIRST NAME:** _____

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

☐ **URGENT**

MEMBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PHONE NUMBER:	**DATE OF BIRTH:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
PATIENT INSURANCE ID NUMBER:	

☐ **MALE** ☐ **FEMALE** **HEIGHT (IN/CM):** _____ **WEIGHT (LB/KG):** _____ **ALLERGIES:** _____

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: HTTPS://MAGELLANRX.COM/MEMBER/EXTERNAL/COMMERCIAL/COMMON/DOC/EN-US/PHI_DISCLOSURE_AUTHORIZATION.PDF

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): _____
AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: _____

PRESCRIBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PRESCRIBER SPECIALTY:	**EMAIL ADDRESS:**
NPI NUMBER:	**DEA NUMBER:**
PHONE NUMBER:	**FAX NUMBER:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
REQUESTOR (if different than prescriber)**:**	**OFFICE CONTACT PERSON:**

MEDICATION OR MEDICAL DISPENSING INFORMATION			
MEDICATION NAME:			
DOSE/STRENGTH:	**FREQUENCY:**	**LENGTH OF THERAPY/REFILLS:**	**QUANTITY:**
☐ **NEW THERAPY** ☐ **RENEWAL**		**IF RENEWAL:** DATE THERAPY INITIATED:	
DURATION OF THERAPY (SPECIFIC DATES):			

Continued on next page.

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1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? ☐ YES (if yes, complete below) ☐ NO		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE)**:**	**DURATION OF THERAPY** (SPECIFY DATES)**:**	**RESPONSE/REASON FOR FAILURE/ALLERGY:**

2. LIST DIAGNOSES:	**ICD-10:**
□ Plaque psoriasis □ Psoriatic arthritis □ Ankylosing spondylitis □ Nonradiographic Axial Spondyloarthritis: □ Other Diagnosis_____ICD-10 Code(s):_____	

3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.

Clinical Information:
Initial Request:
Is drug being used as part of a clinical trial? □ Yes □ No

Is the patient on concurrent treatment with another TNF inhibitor? □ Yes □ No

Has the patient tried and had an inadequate response to a three month trial of Enbrel?* □ Yes □ No
Must provide documentation, including trial dates.

Has the patient tried and had an inadequate response to a three month trial of Humira?* □ Yes □ No
Must provide documentation, including trial dates.

Is Taltz prescribed by a dermatologist? □ Yes □ No
Is Taltz prescribed by a rheumatologist? □ Yes □ No

For Request Plaque Psoriasis, also answer the following:
Does the patients have plaques covering greater than or equal to 3% of their body surface area (BSA)? □ Yes □ No

Does the patient have plaques covering less than 3% of BSA with involvement of palms, soles, head and neck, or genitalia which causes disruption of normal activities? □ Yes □ No

Has the patient had an inadequate response to a topical therapy (e.g., corticosteroids, anthralin, calcipotriene tazarotene)? □ Yes □ No
If "yes" to the above question, please provide supporting documentation, including which agent(s) have been tried and trial dates: _____

Select if the patient has had an inadequate response to previous treatment with the following phototherapies:
□ Psoralens with UVA light (PUVA)
□ UVB with coal tar
Please provide supporting documentation, including which agent(s) have been tried and trial dates: _____
_____

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Select if the patient has tried and had an inadequate response to the following oral systemic therapies:

- □ **Acitretin**
- □ **Methotrexate**
- □ **Cyclosporine**

Please provide supporting documentation, including which agent(s) have been tried and trial dates: _____

_____

Select if the patient has a contraindication to ALL of the follow ing oral systemic therapies:*

- □ **Acitretin**
- □ **Methotrexate**
- □ **Cyclosporine**

Please submit documentation of the contraindications to all three drugs.

For Request of Ankylosing Spondylitis, also answer the following:

Has patient had a trial of at least two (2) NSAIDs OR has patient had a trial of one NSAID AND methotrexate?
□ **Yes** □ **No**

For Request of Nonradiographic Axial Spondyloarthritis, also answer the following:

Did the patient's back pain begin before age 45 years ? □ **Yes** □ **No**

Does the patient have objective signs of inflammation by presence of sacroiliitis on MRI?
□ **Yes** □ **No** ***Please submit MRI report.***

Does the patient have objective signs of inflammation by presence of an elevated C-reactive protein level?
□ **Yes** □ **No** ***Please submit lab report***

Has the patient had an inadequate response to at least two different NSAIDs for at least 4 weeks?
□ **Yes** □ **No** ***Please submit documentation.***

Is the patient intolerant of NSAIDs? □ **Yes** □ **No** ***Please submit documentation.***

Does the patient have radiographic sacroiliitis (per 1984 modified New York criteria)? □ **Yes** □ **No** ***Please submit imaging (x-ray) report.***

Has the patient received prior treatment with other biologic therapy, TNF inhibitors or other immunomodulatory agents? □ **Yes** □ **No**

Renewal Requests:

Is Taltz prescribed by a dermatologist? □ **Yes** □ **No**
Is Taltz prescribed by a rheumatologist? □ **Yes** □ **No**
Is patient continuing to respond to therapy? □ **Yes** □ **No** ***Please submit documentation.***

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Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received.

ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature or Electronic I.D. Verification: _____ **Date:** _____

FAX THIS FORM TO: 800-424-7640

MAIL REQUESTS TO: Magellan Rx Management Prior Authorization Program
Attn: CP – 4201
P.O. Box 64811
St. Paul, MN 55164-0811