



**Taltz (Ixekizumab)
Prior Authorization Request Form**



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

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](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:
<input type="checkbox"/> NEW THERAPY	<input type="checkbox"/> RENEWAL	IF RENEWAL: DATE THERAPY INITIATED:	
DURATION OF THERAPY (SPECIFIC DATES):			

Continued on next page.





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

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:**

<input type="checkbox"/> Plaque psoriasis <input type="checkbox"/> Psoriatic arthritis <input type="checkbox"/> Nonradiographic Axial Spondyloarthritis: <input type="checkbox"/> Other Diagnosis _____ ICD-10 Code(s): _____	
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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 following oral systemic therapies:*

- Acitretin
- Methotrexate
- Cyclosporine

**Please submit documentation of the contraindications to all three drugs.*

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.*

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





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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:** _____

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FAX THIS FORM TO: 800-424-7640

MAIL REQUESTS TO: Magellan Rx Management Prior Authorization Program; c/o Magellan Health, Inc.
4801 E. Washington Street, Phoenix, AZ 85034
Phone: 877-228-7909

