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

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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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:**
□ Plaque psoriasis □ Psoriatic arthritis □ Other Diagnosis_____ICD-10 Code(s):_____	

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

Clinical Information:

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 Initial Request Plaque Psoriasis:

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: _____
_____

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

□ Acitretin

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

□ **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.

Renewal for Psoriasis:
Is prescriber a dermatologist? □ Yes □ No
Has patient had a continued positive response to therapy? □ Yes □ No *Please submit documentation.*

For Initial Request of Psoriatic Arthritis:
Has the patient had a trial and failure of an oral DMARD such as methotrexate, azathioprine (Imuran®), sulfasalazine (Azulfidine®), leflunamide (Arava®) ? □ Yes □ No
Please submit documentation of the dates of service.

Renewal for Psoriatic Arthritis:
Is prescriber a rheumatologist or dermatologist? □ Yes □ No
Has patient had a continued positive response 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?

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; c/o Magellan Health, Inc.
4801 E. Washington Street, Phoenix, AZ 85034
Phone: 877-228-7909