UTAH MEDICAID PHARMACY PRIOR AUTHORIZATION REQUEST FORM

Taltz (ixekizumab)

Member and Medication Information * indicates required field	
*Member ID:	*Member Name:
*DOB:	*Weight:
*Medication Name/ Strength:	
☐ Do Not Substitute. Authorizations will be processed for the preferred Generic/Brand equivalent unless specified.	
*Directions for use:	
Provider Information * indicates required field	
*Requesting Provider Name:	*Requesting Prescriber NPI:
Address:	
*Contact Person:	*Office Phone:
*Office Fax:	*Office Email:
Fax form and relevant documentation including: laboratory results, chart notes and/or updated provider letter to Pharmacy PA at **855-828-4992**, to prevent processing delays.	

PART I: Criteria for Approval: (*All* of the following criteria must be met) - **Then move to PART II**

1. Is the medication being prescribed by or in consultation with a provider specializing in the disease treatment? ❑ **Yes** ❑ **No**
2. Does the patient have any of the following diagnoses:? (check the applicable) ❑ **Yes** ❑ **No**
   - ☐ Ankylosing Spondylitis (AS)
   - ☐ Non-radiographic Axial Spondyloarthritis (nr-axSpA)
   - ☐ Plaque Psoriasis (PsO)
   - ☐ Psoriatic Arthritis (PsA)
   - ☐ Other - Off Label or Compendia Use (specify): _____
3. Does the provider attest that the patient is not taking concurrent treatment or that the medication will not be used in combination with other TNF-inhibitors, biologic response modifiers or other biologic DMARDs, Janus kinase Inhibitors, or Phosphodiesterase 4 inhibitors (i.e., apremilast, tofacitinib, baricitinib) as verified by prescriber attestation, patient medication fill history, or submitted documentation? ❑ **Yes** ❑ **No**
4. Does the requested medication and diagnosis follow FDA-approved age, dosing, monitoring and contraindications? ❑ **Yes** ❑ **No**
   *If answer is **No**, go to Part II, section 5*
5. Has the patient tried and failed, demonstrated an intolerance to, or has a contraindication to the preferred TNF, if applicable? ❑ **Yes** ❑ **No**

PART II: Select and fill out applicable sections:

Section 1: Additional criteria for Ankylosing Spondylitis (AS) (*All* of the following criteria must be met)

1. Is the patient at least 18 years of age or older? ❑ **Yes** ❑ **No**
2. Does the patient have a diagnosis of Ankylosing Spondylitis demonstrated by description of baseline symptoms present in the chart notes? ❑ **Yes** ❑ **No**

Section 2: Additional criteria for Non-radiographic Axial Spondyloarthritis (nr-axSpA) (*All* of the following criteria must be met)

1. Is the patient at least 18 years of age or older? ❑ **Yes** ❑ **No**
2. Does the patient have a diagnosis of active non-radiographic axial spondyloarthritis (nr-axSpA) with objective signs of inflammation demonstrated by description of baseline symptoms present in the chart notes? ❑ **Yes** ❑ **No**

Section 3: Additional criteria for Plaque Psoriasis (PsO) (*All* of the following criteria must be met)

1. Is the patient at least 6 years of age or older? ❑ **Yes** ❑ **No**
2. Has the patient been diagnosed with moderate to severe plaque psoriasis involving greater than 3% body surface area? ❑ **Yes** ❑ **No**
3. If less than 3% of the body is involved, is there scalp, palmar, foot, or groin involvement causing significant disability? ❑ **Yes** ❑ **No**

Section 4: Additional criteria for Psoriatic Arthritis (PsA) (*All* of the following criteria must be met)

1. Is the patient at least 18 years of age or older? ❑ **Yes** ❑ **No**
2. Does the patient have a diagnosis of active psoriatic arthritis demonstrated by description of baseline symptoms present in the chart notes? ❑ **Yes** ❑ **No**

Section 5: Other - Off Label or Compendia Use of FDA-Approved Drugs Additional Criterion:

1. Does the submitted clinical documentation show an adequate trial and failure of at least **ONE** FDA-labeled and Medicaid preferred medication, if applicable? ❑ **Yes** ❑ **No**
2. Does the provider attest that the requested drug is being used for a medically accepted indication that is supported by information from the appropriate *compendia** of current literature. Including at least (1) major multi-site study or three (3) smaller studies published in JAMA, NEJM, Lancet, or other peer review specialty medical journals in the most recent years? ❑ **Yes** ❑ **No**

* Compendia use must be recommended by generally accepted compendia such as American Hospital Formulary Service Drug Information (AHFS), United States Pharmacopeia-Drug Information (USP-DI), the Micromedex Information System, Pediatric and Neonatal Lexi-Drugs, or clinical guidelines.

Reauthorization Criteria:

1. Has the provider submitted updated chart notes demonstrating a positive clinical response? ❑ **Yes** ❑ **No**

Initial Authorization: Up to six (6) months
Reauthorization: Up to one (1) year

PROVIDER CERTIFICATION

I hereby certify this treatment is indicated, necessary and meets the guidelines for use.

_____ _____

Prescriber's Signature Date