PARAMOUNT
Affiliate of ProMedica

Criteria: PMT
Approved:1/2018
Verified: 12/2019
Reviewed:

Prior Authorization Criteria Form

This form applies to Paramount Commercial Members Only

Taltz

Complete/review information, sign and date. Please fax signed forms to Paramount at **1-844-256-2025**. You may contact Paramount by phone at **1-419-887-2520** with questions regarding the Prior Authorization process. When conditions are met, we will authorize the coverage of Taltz.

Drug Name (select from list of drugs shown)

Taltz Autoinjector (ixekizumab) Taltz Prefilled Syringe (ixekizumab)

Quantity _____ **Frequency** _____ **Strength** _____

Route of Administration _____ **Expected Length of Therapy** _____

Patient Information

Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone:

Prescribing Physician

Physician Name: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please circle the appropriate answer for each question.

1. Has the patient previously received Taltz for one of the following conditions: A) plaque psoriasis or B) psoriatic arthritis? Y N
[If yes, skip to question 3.]

2. Has documentation to support continued clinical effectiveness been submitted with the renewal request? Y N
[If yes, skip to question 14.]
[If no, no further questions.]

3. These are the preferred products for treatment of the following conditions: Plaque psoriasis: Enbrel, Humira, Cosentyx, Otezla, Stelara. Psoriatic arthritis: Enbrel, Humira, Cosentyx, Otezla, Stelara, Xeljanz/Xeljanz XR. Has at least one preferred agent from each therapeutic class been tried and failed, or is contraindicated? If yes, please submit supporting documentation. Y N
[If no, no further questions.]

4. Is Taltz prescribed for a patient with moderate to severe plaque psoriasis? Y N
[If no, skip to question 10.]

5. Does the patient meet one of the following criteria: A) At least 5 percent of the body surface area was affected by plaque psoriasis at the time of diagnosis, B) Crucial body areas (e.g., feet, hands, face, neck, groin, intertriginous areas) were affected by plaque psoriasis at the time of diagnosis? Y N
[If no, no further questions.]

6. Does the patient have an inadequate response, intolerance or contraindication to BOTH of the following: A) a three to four month trial of phototherapy, B) a three to four month trial of pharmacologic treatment with methotrexate, cyclosporine, or acitretin? Action Required: If Yes , attach office notes and clinical documentation for the response given. Y N
[If no, no further questions.]

7. Does the patient have one of the following documented clinical reasons to avoid Enbrel or Humira? If Yes , attach supporting chart note(s). Y N
- History of demyelinating disorder
- History of congestive heart failure
- History of hepatitis B virus infection
- Autoantibody formation/lupus-like syndrome
- Risk of lymphoma
[If no, skip to question 9.]

8. Has the patient had a documented inadequate response or intolerable adverse event with all of the non-TNF preferred products (Cosentyx, Otezla, and Stelara)? Action Required: If Yes , attach supporting chart note(s). Y N
[If yes, skip to question 14.]
[If no, no further questions.]

9. Has the patient had a documented inadequate response or intolerable adverse event with at least one preferred agent from each therapeutic class (Cosentyx, Enbrel or Humira, Otezla and Stelara)? Action Required: If Yes , attach supporting chart note(s). Y N
[If yes, skip to question 14.]
[If no, no further questions.]

10. Is Taltz requested for a patient with active psoriatic arthritis (PsA)? Y N
[If no, no further questions.]

11. Does the patient have one of the following documented clinical reasons to avoid Enbrel and Humira? If Yes , attach supporting chart note(s). Y N
- History of demyelinating disorder
- History of congestive heart failure
- History of hepatitis B virus infection
- Autoantibody formation/lupus-like syndrome
- Risk of lymphoma
[If no, skip to question 13.]

12. Has the patient had a documented inadequate response or intolerable adverse event with all of the non-TNF preferred products (Cosentyx, Otezla, Stelara and Xeljanz/Xeljanz XR)? Action Required: If Yes , attach supporting chart note(s).
[If yes, skip to question 14.]
[If no, no further questions.]

Y N

13. Has the patient had a documented inadequate response or intolerable adverse event with at least one preferred agent from each therapeutic class (Cosentyx, Enbrel or Humira, Otezla, Stelara and Xeljanz/Xeljanz XR)? Action Required: If Yes , attach supporting chart note(s).
[If no, no further questions.]

Y N

14. Is the patient 18 years of age or older?

Y N

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature and Date