PRIOR AUTHORIZATION REQUEST
Taltz

PATIENT: Name_____
Address: _____
City, State, Zip_____
D.O.B. _____
Member ID:_____

Prescriber: Name_____
Address _____
City, State, Zip_____
Phone _____
Fax _____
NPI _____

Medication Requested:_____ Qty Requested: _____

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please answer the following questions

1. Will the requested medication be given in combination with a BIOLOGIC disease-modifying antirheumatic drug (DMARD) or in combination with a targeted synthetic DMARD?
   - ☐ Biologic DMARD
   - ☐ Targeted synthetic DMARD
   - ☐ Conventional synthetic DMARD
   - ☐ No, the requested medication will NOT be used in combination with another BIOLOGIC or Targeted Synthetic disease-modifying antirheumatic drug (DMARD)
2. What is the indication or diagnosis?
   - ☐ Ankylosing spondylitis – **Please answer questions 3, 4, 5**
   - ☐ Plaque psoriasis – **Please answer questions 3, 6 - 10**
   - ☐ Psoriatic arthritis – **Please answer questions 3, 11, 12**
   - ☐ Non-radiographic axial spondyloarthritis – **Please answer questions 3, 4, 13, 14, 15**
   - ☐ Inflammatory bowel disease (that is, Crohn's disease, ulcerative colitis)
   - ☐ Other indications – (Please Specify) _____
3. ☐ Yes ☐ No Is the patient currently receiving the requested medication?
4. ☐ Yes ☐ No Is the requested medication being prescribed by or in consultation with a rheumatologist?
5. ☐ Yes ☐ No Has the patient had a response, as determined by the prescriber?
6. ☐ Yes ☐ No Has the patient tried at least one traditional systemic agent for psoriasis for at least 3 months, unless intolerant?
7. ☐ Yes ☐ No Has the patient already had a 3-month trial or previous intolerance to at least one biologic?
8. ☐ Yes ☐ No Does the patient have a contraindication to methotrexate, as determined by the prescribing physician?
9. ☐ Yes ☐ No Is the requested medication being prescribed by or in consultation with a

If you have any questions, call: 800-753-2851

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dermatologist?

10. ☐ Yes ☐ No Has the patient had a response, as determined by the prescriber?
11. ☐ Yes ☐ No Has the patient had a response, as determined by the prescriber?
12. ☐ Yes ☐ No Is the requested medication being prescribed by or in consultation with a rheumatologist or a dermatologist?
13. ☐ Yes ☐ No Has the patient had a response, as determined by the prescriber?
14. ☐ Yes ☐ No Does the patient have objective signs of inflammation, defined as C-reactive protein elevated beyond the upper limit of normal for the reporting laboratory?
15. ☐ Yes ☐ No Does the patient have objective signs of inflammation, defined as sacroiliitis reported on magnetic resonance imaging?

Please document the diagnoses, symptoms, and/or any other information important to this review:

SECTION B Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 877-251-5896

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