maryland physicians care
Medicaid with a Heart

PRIOR AUTHORIZATION REQUEST

Taltz

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

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 note that supporting clinical documentation is required for **ALL** PA requests.

1	Will the requested medication be used in combination with a biologic disease-modifying antirheumatic drug (DMARD) or targeted synthetic DMARD used for an inflammatory condition? [Note: Examples of biologics include but not limited to Actemra (IV or SC), Kevzara, Cosentyx, Kineret, Orencia (IV or SC), a rituximab product (for example, Rituxan, Truxima), Cimzia, Enbrel, Humira, an infliximab product (for example, Remicade, Inflectra, Renflexis), Simponi (Aria or SC), Ilumya, Siliq, Stelara (IV or SC), or Taltz. Examples of targeted synthetic DMARD include but not limited to Xeljanz/XR, Olumiant, Rinvoq, or Otezla.] [If yes, no further questions.]	Yes	No
2	Is the patient currently receiving the requested medication?	Yes	No

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	[If no, skip to question 18.]		
3	Has the patient been receiving medication samples for the requested medication? [If yes, skip to question 18.]	Yes	No
4	Does the patient have a previously approved PA on file with the current plan? [Note: If the patient does NOT have a previously approved PA on file for the requested medication with the current plan, the renewal request will be considered under initial therapy.] [If yes, skip to question 6.]	Yes	No
5	Has documentation been provided to confirm that the patient has had a clinically significant response to the requested medication, as determined by the provider? ACTION REQUIRED: Submit supporting documentation. [If yes, skip to question 18.] [If no, no further questions.]	Yes	No
6	Has the patient been established on therapy for AT LEAST 3 months? [If no, skip to question 18.]	Yes	No
7	What is the patient's diagnosis? [] Ankylosing spondylitis (If checked, go to 8) [] Plaque psoriasis (If checked, go to 14) [] Psoriatic arthritis (If checked, go to 16) [] Non-radiographic axial spondyloarthritis (If checked, go to 11) [] Inflammatory bowel disease (that is, Crohn's disease, ulcerative colitis) (If checked, no further questions) [] Other (If checked, no further questions)		
8	Has documentation been provided to confirm that the patient has had a clinically significant response to the requested medication, as determined by the provider? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
9	Has documentation been provided to confirm that the patient has experienced a beneficial documented clinical response from baseline, when assessed by AT LEAST ONE objective measure? ACTION REQUIRED: Submit supporting documentation. [Note: Examples of objective measures include Ankylosing Spondylitis Disease Activity Score (ASDAS), Ankylosing Spondylitis Quality of Life Scale (ASQoL), Bath Ankylosing Spondylitis Disease Activity Index (BASDAI), Bath Ankylosing Spondylitis Functional Index (BASFI), Bath Ankylosing Spondylitis Global Score (BAS-G), Bath Ankylosing Spondylitis Metrology Index (BASMI), Dougados	Yes	No

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	Functional Index (DFI), Health Assessment Questionnaire for the Spondylarthropathies (HAQ-S), and/or serum markers (such as: C-reactive protein, erythrocyte sedimentation rate).] [If yes, no further questions.]		
10	Compared with baseline, Has the patient experienced an improvement in AT LEAST ONE symptom, such as decreased pain or stiffness, or improvement in function or activities of daily living? [No further questions.]	Yes	No
11	Has documentation been provided to confirm that the patient has had a clinically significant response to the requested medication, as determined by the provider? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
12	Has documentation been provided to confirm that the patient has experienced a beneficial clinical response from baseline, when assessed by AT LEAST ONE objective measure? ACTION REQUIRED: Submit supporting documentation. [If yes, no further questions.]	Yes	No
13	Compared with baseline, Has the patient experienced an improvement in AT LEAST ONE symptom, such as decreased pain or stiffness, or improvement in function or activities of daily living? [No further questions.]	Yes	No
14	Has the patient experienced a beneficial clinical response, defined as improvement from baseline (prior to initiating the requested drug), in AT LEAST ONE of the following: A) Estimated body surface area, B) Erythema, C) Induration/thickness, D) Scale of areas affected by psoriasis? [If yes, no further questions.]	Yes	No
15	Compared with baseline, has the patient experienced an improvement in AT LEAST ONE symptom, such as decreased pain, itching, and/or burning? [No further questions.]	Yes	No
16	Has the patient experienced a beneficial clinical response from baseline when assessed by AT LEAST ONE objective measure? [Note: Examples of objective measures of disease activity include Disease Activity Index for Psoriatic Arthritis (DAPSA), Composite Psoriatic Disease Activity Index (CPDAI), Psoriatic Arthritis Disease Activity Score (PsA DAS), Grace Index, Leeds Enthesitis Score (LEI), Spondyloarthritis Consortium of Canada (SPARCC) enthesitis score, Leeds Dactylitis Instrument Score, Minimal Disease Activity (MDA), Psoriatic Arthritis Impact of Disease (PsAID-12), and/or serum markers (for example, C-reactive protein, erythrocyte sedimentation rate).] [If yes, no further questions.]	Yes	No
17	Compared with baseline, has the patient experienced an improvement in AT LEAST ONE symptom, such as decreased joint pain, morning stiffness, or fatigue;	Yes	No

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	improved function or activities of daily living; decreased soft tissue swelling in joints or tendon sheaths? [No further questions.]		
18	What is the indication or diagnosis? [] Ankylosing spondylitis (If checked, go to 19) [] Plaque psoriasis (If checked, go to 25) [] Psoriatic arthritis (If checked, go to 30) [] Non-radiographic axial spondyloarthritis (If checked, go to 23) [] Inflammatory bowel disease (that is, Crohn's disease, ulcerative colitis) (If checked, no further questions) [] Other (If checked, no further questions)		
19	Is the requested medication being prescribed by or in consultation with a rheumatologist? [If no, no further questions.]	Yes	No
20	Has documentation been provided to confirm that the patient has an intolerance, contraindication to, or failed treatment for AT LEAST 3 months with preferred TNF inhibitors, Enbrel (etanercept) and an adalimumab product (Hadlima, Yusimry, or adalimumab- adbm)? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
21	Has documentation been provided to confirm that the patient has an intolerance, contraindication to, or failed treatment for AT LEAST 3 months with Xeljanz (tofacitinib)? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
22	Does the dose of the requested medication exceed FDA approved label dosing for the indication? [No further questions.]	Yes	No
23	Is the requested medication being prescribed by or in consultation with a rheumatologist? [If no, no further questions.]	Yes	No
24	Has the patient had an objective sign of inflammation, defined as AT LEAST ONE of the following: A) C-reactive protein elevated beyond the upper limit of normal for the reporting laboratory, B) Sacroiliitis reported on magnetic resonance imaging? [No further questions.]	Yes	No
25	Is the patient greater than or equal to 6 years of age? [If no, no further questions.]	Yes	No

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26	Is the requested medication being prescribed by or in consultation with a dermatologist? [If no, no further questions.]	Yes	No
27	Has the patient tried AT LEAST TWO traditional systemic agents for psoriasis for AT LEAST 3 months or was intolerant traditional systemic agents? [Note: Examples include methotrexate (MTX), cyclosporine, acitretin (Soriatane, generics), or psoralen plus ultraviolet A light (PUVA).] [If no, no further questions.]	Yes	No
28	Has documentation been provided to confirm that the patient has an intolerance, contraindication to, or failed treatment for AT LEAST 3 months with preferred TNF inhibitors, Enbrel (etanercept) and an adalimumab product (Hadlima, Yusimry, or adalimumab- adbm)? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
29	Does the dose of the requested medication exceed FDA approval label for the indication? [No further questions.]	Yes	No
30	Is the requested medication being prescribed by or in consultation with a rheumatologist or a dermatologist? [If no, no further questions.]	Yes	No
31	Has documentation been provided to confirm that the patient has an intolerance, contraindication to, or failed treatment for AT LEAST 3 months with preferred TNF inhibitors, Enbrel (etanercept) and an adalimumab product (Hadlima, Yusimry, or adalimumab- adbm)? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
32	Has documentation been provided to confirm that the patient has an intolerance, contraindication to, or failed treatment for AT LEAST 3 months with Xeljanz (tofacitinib)? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
33	Has the patient tried TWO conventional synthetic disease-modifying antirheumatic drug (DMARD) for AT LEAST 3 months or was intolerant to conventional synthetic DMARDs? [Note: Examples of conventional synthetic DMARDs include methotrexate (oral or injectable), leflunomide, hydroxychloroquine, and sulfasalazine.] [If no, no further questions.]	Yes	No
34	Does the dose of the requested medication exceed FDA approval label for the indication?	Yes	No

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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: 1-833-896-0656

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

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