



## 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. Pharmacy prior authorization reviews can be subject to trial with additional medications that are not listed within the criteria. The policies are subject to change based on COMAR requirements, MDH transmittals and updates to treatment guidelines.

1      Is the request an INITIAL or CONTINUATION of therapy?

Initial (If checked, go to 6)

Continuation (If checked, go to 2)

2      Is the patient currently receiving the requested medication? Yes      No

[If no, skip to question 6.]

**If you have any  
questions, call:  
1-888-258-8250**

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3	Has the patient been receiving medication samples of the requested medication? [If yes, skip to question 6.]	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 no, skip to question 6.]	Yes	No
5	Has the patient been taking the requested medication for AT LEAST 3 months and has experienced a clinically significant benefit from the medication, as documented by the prescriber? ACTION REQUIRED: Submit supporting documentation. [No further questions.]	Yes	No
6	What is the indication or diagnosis? <input type="checkbox"/> Ankylosing spondylitis (If checked, go to 7)  <input type="checkbox"/> Non-radiographic axial spondyloarthritis (If checked, go to 12)  <input type="checkbox"/> Plaque psoriasis (If checked, go to 17)  <input type="checkbox"/> Psoriatic arthritis (If checked, go to 24)  <input type="checkbox"/> Other (If checked, no further questions)		
7	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No
8	Is the requested medication being prescribed by or in consultation with a rheumatologist? [If no, no further questions.]	Yes	No
9	Has documentation been submitted to confirm that the patient has had a treatment failure with an adalimumab product (Hadlima, Simlandi, Yusimry, or adalimumab-adbm) for AT LEAST 3 months unless intolerant or contraindicated? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
10	Has documentation been submitted to confirm that the patient has had a treatment failure with Xeljanz (tofacitinib) for AT LEAST 3 months, unless intolerant or contraindicated? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
11	Does the dose of the requested medication exceed the Food and Drug Administration (FDA) approved label dosing for the indication? [Dosing: 160 mg SQ once, followed by 80 mg SQ every 4 weeks.] [No further questions.]	Yes	No

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12	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No
13	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? [If no, no further questions.]	Yes	No
14	Has documentation been submitted to confirm that the patient has had a treatment failure with an adalimumab product (Hadlima, Simlandi, Yusimry, or adalimumab-adbm) AND Cimzia (certolizumab) for AT LEAST 3 months unless intolerant or contraindicated? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
15	Is the requested medication being prescribed by or in consultation with a rheumatologist? [If no, no further questions.]	Yes	No
16	Does the dose of the requested medication exceed the Food and Drug Administration (FDA) approved label dosing for the indication? [Dosing: 80 mg SQ every 4 weeks.] [No further questions.]	Yes	No
17	Is the patient greater than or equal to 6 years of age? [If no, no further questions.]	Yes	No
18	Is the requested medication being prescribed by or in consultation with a rheumatologist or dermatologist? [If no, no further questions.]	Yes	No
19	Has documentation been submitted to confirm that the patient has had a treatment failure with AT LEAST TWO traditional systemic agents for AT LEAST 3 months unless intolerant or contraindicated? ACTION REQUIRED: Submit supporting documentation. [Note: Examples include methotrexate (MTX), cyclosporine, acitretin (Soriatane, generics).] [If no, no further questions.]	Yes	No
20	Has documentation been submitted to confirm that the patient has had treatment failure with daily use of Zoryve for AT LEAST 56 consecutive days, or is the patient intolerant or the medication contraindicated? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
21	Has documentation been submitted to confirm that the patient has had a treatment failure with an adalimumab product (Hadlima, Simlandi, Yusimry, or adalimumab-	Yes	No

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adbm) for AT LEAST 3 months unless intolerant or contraindicated? ACTION REQUIRED: Submit supporting documentation.  
[If no, no further questions.]

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|----|--|-----|----|
| 22 | Has documentation been submitted to confirm that the patient has had a treatment failure with a preferred ustekinumab product (Yesintek, Pyzchiva, Steqeyma), for AT LEAST 3 months unless intolerant or contraindicated? ACTION REQUIRED: Submit supporting documentation.<br>[If no, no further questions.]  | Yes | No |
| 23 | Does the dose of the requested medication exceed the Food and Drug Administration (FDA) approval label for the indication?<br>[Dosing: 160 mg SQ once, followed by 80 mg SQ at weeks 2, 4, 6, 8, 10, and 12, and then 80 mg every 4 weeks.]<br>[No further questions.]   | Yes | No |
| 24 | Is the patient greater than or equal to 18 years of age?<br>[If no, no further questions.]   | Yes | No |
| 25 | Is the requested medication being prescribed by or in consultation with a rheumatologist or a dermatologist?<br>[If no, no further questions.]   | Yes | No |
| 26 | Has documentation been submitted to confirm that the patient has had a treatment failure with AT LEAST 2 conventional systemic therapies for AT LEAST 3 months unless intolerant or contraindicated? ACTION REQUIRED: Submit supporting documentation. [Note: Examples include leflunomide, hydroxychloroquine, sulfasalazine, or methotrexate.]<br>[If no, no further questions.] | Yes | No |
| 27 | Has documentation been submitted to confirm that the patient has had a treatment failure with an adalimumab product (Hadlima, Simlandi, Yusimry, or adalimumab-adbm) for AT LEAST 3 months unless intolerant or contraindicated? ACTION REQUIRED: Submit supporting documentation.<br>[If no, no further questions.]   | Yes | No |
| 28 | Has documentation been submitted to confirm that the patient has had a treatment failure with a preferred ustekinumab product (Yesintek, Pyzchiva, Steqeyma), for AT LEAST months unless intolerant or contraindicated? ACTION REQUIRED: Submit supporting documentation.<br>[If no, no further questions.]  | Yes | No |
| 29 | Has documentation been submitted to confirm that the patient has had a treatment failure with Xeljanz (tofacitinib) for AT LEAST 3 months, unless intolerant or contraindicated? ACTION REQUIRED: Submit supporting documentation.<br>[If no, no further questions.]   | Yes | No |

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30	Does the dose of the requested medication exceed the Food and Drug Administration (FDA) approval label for the indication? [Dosing: 160 mg SQ once, followed by 80 mg SQ every 4 weeks.]	Yes	No
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*Please document the diagnoses, symptoms, and/or any other information important to this review:*

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### **SECTION B:** Physician Signature

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PHYSICIAN SIGNATURE	DATE
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**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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