SENTARA COMMUNITY PLAN
(MEDICAID)

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: Taltz® SQ (ixekizumab) **(self-administered, Pharmacy) (Non-Preferred)**

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight (if applicable): _____ **Date weight obtained:** _____

Indication	Dosage
Moderate-to-Severe Plaque Psoriasis (Adults) – who are candidates for systemic therapy or phototherapy	• Two 80mg injections initially for 14 days, • Then, two 80mg/28 days until week 12 • Then, one 80mg injection every 28 days
Moderate-to-Severe Plaque Psoriasis (Children ≥ 6 years) - who are candidates for systemic therapy or phototherapy	• In pediatrics weight based: • >50 kg: Two 80 mg injections/28 days initially, then one 80 mg injection/28 days • 25-50 kg: Two 40 mg injections/28 days initially, then one 40 mg injection/28 days • <25kg: Two 20 mg injections/28 days initially, then one 20 mg injection/28 days
Active Psoriatic Arthritis (PsA)	• Two 80mg injections/28days, then one 80mg injection every 4 weeks

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Indication	Dosage
Active Ankylosing Spondylitis	• Two 80mg injections/28days, then one 80mg injection every 4 weeks
Active non-radiographic axial spondyloarthritis (nr-axSpA) with objective signs of inflammation (Adults)	• One 80mg injection subcutaneously every 4 weeks

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

DIAGNOSIS: (Check below the applicable diagnosis or authorization will be delayed or denied)

❑ Moderate to Severe Plaque Psoriasis

- ❑ Moderate-to-severe active **Chronic Plaque Psoriasis** who are candidates for systemic therapy or phototherapy
- ❑ Member is at least 6 years of age or older
- ❑ Trial and failure of at least **TWO (2)** topical treatments, such as corticosteroids, calcipotriene, coal tar, tazarotene, or anthralin. List drugs below:

  1. _____ 2. _____

- ❑ Trial and failure of **TWO (2)** of the preferred drugs below:

❑ adalimumab-adbm (Boehringer Ingelheim) **OR** Hadlima® (adalimumab-bwwd)	❑ Enbrel®	❑ Pyzchiva® syringe/vial (Requires trial and failure of a preferred TNF-alpha inhibitor)

❑ Active Psoriatic Arthritis (PsA)

- ❑ Member is 18 years of age or older
- ❑ Trial and failure of **TWO (2)** of the preferred drugs below:

❑ adalimumab-adbm (Boehringer Ingelheim) **OR** Hadlima® (adalimumab-bwwd)	❑ Enbrel®	❑ Pyzchiva® syringe/vial (Requires trial and failure of a preferred TNF-alpha inhibitor)

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❑ Ankylosing Spondylitis

- ❑ Member is 18 years of age or older
- ❑ Trial and failure of **BOTH** of the preferred drugs below:

❑ adalimumab-adbm (Boehringer Ingelheim) **OR** Hadlima® (adalimumab-bwwd)	❑ Enbrel®

❑ Non-Radiographic Axial Spondyloarthritis

- ❑ Member is 18 years of age or older
- ❑ Member has objective signs of inflammation
- ❑ Trial and failure of **BOTH** of the preferred drugs below:

❑ adalimumab-adbm (Boehringer Ingelheim) **OR** Hadlima® (adalimumab-bwwd)	❑ Enbrel®

Medication being provided by Specialty Pharmacy - PropriumRx

Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.

**Previous therapies will be verified through pharmacy paid claims or submitted chart note*

REVISED/UPDATED/REFORMATTED: ~~6/26/2023; 11/10/2023,~~3/20/~~2025,03/26/2025, 10/17/2025,~~ **12/15/2025**