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:** _____

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

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

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

Weight: _____ **Date:** _____

Recommended Dose:

Indication	Dosage
❑ **Moderate-to-Severe Plaque Psoriasis (Adults) –** who are candidates for systemic therapy or phototherapy	• Four 80mg injections initially for 28 days, • Then, two 80mg injection lasting until week 10 • 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: • Initial from 40mg to 160mg one time • Then, every 4-week dosing thereafter ranges from 20mg to 80mg
❑ **Active Psoriatic Arthritis. (PsA)**	• Two 80mg injection initially then one 80mg injection every 4 weeks
❑ **Ankylosing Spondylitis**	• Two 80mg injection initially then one 80mg injection every 4 weeks
❑ **Active non-radiographic axial spondyloarthritis (nr-axSpA) with objective sign of inflammation (Adults)**	• One 80mg injection subcutaneously every 4 weeks

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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.

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

Prescriber is a: ❑ **Dermatologist** ❑ **Rheumatologist**

❑ Moderate to Severe Plaque Psoriasis

- ❑ Moderate-to-severe active **Chronic Plaque Psoriasis** who are candidates for systemic therapy or phototherapy

AND

- ❑ Member is at least 6 years of age or older

AND

- ❑ 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, contraindication, or adverse reaction to methotrexate

AND

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

❑ Humira®	❑ Enbrel®	❑ Infliximab

❑ Active Psoriatic Arthritis (PsA)

- ❑ Trial and failure of, contraindication, or adverse reaction to methotrexate

AND

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

❑ Humira®	❑ Enbrel®	❑ Infliximab

❑ Ankylosing Spondylitis

- ❑ Trial and failure of an adequate trial of at least **two (2) NSAIDS**

OR

- ❑ Use of NSAIDs is contraindicated in patient

AND

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- ❑ Trial and failure of, contraindication, or adverse reaction to methotrexate

AND

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

❑ Humira®	❑ Enbrel®	❑ Infliximab

❑ Non-Radiographic Axial Spondyloarthritis

- ❑ Member has objective signs of inflammation

AND

- ❑ Trial and failure of an adequate trial of at least **two (2) NSAIDS**

OR

- ❑ Use of NSAIDs is contraindicated in patient

AND

- ❑ Trial and failure of, contraindication, or adverse reaction to methotrexate

AND

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

❑ Humira®	❑ Enbrel®

Medication being provided by a 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 notes.*