

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: _____

Indication	Dosage
Moderate-to-Severe Plaque Psoriasis (Adults) – who are candidates for systemic therapy or phototherapy	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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)	<ul style="list-style-type: none"> • Two 80mg injections/28days, then one 80mg injection every 4 weeks

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Indication	Dosage
Active Ankylosing Spondylitis	<ul style="list-style-type: none"> Two 80mg injections/28days, then one 80mg injection every 4 weeks
Active non-radiographic axial spondyloarthritis (nr-axSpA) with objective signs of inflammation (Adults)	<ul style="list-style-type: none"> 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:

<input type="checkbox"/> adalimumab-adbm (Boehringer Ingelheim) OR Hadlima [®] (adalimumab-bwwd)	<input type="checkbox"/> Enbrel [®]	<input type="checkbox"/> Pyzchiva [®] syringe/vial OR Starjemza [™] (Requires trial and failure of a preferred TNF-alpha inhibitor)
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Active Psoriatic Arthritis (PsA)

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

<input type="checkbox"/> adalimumab-adbm (Boehringer Ingelheim) OR Hadlima [®] (adalimumab-bwwd)	<input type="checkbox"/> Enbrel [®]	<input type="checkbox"/> Pyzchiva [®] syringe/vial OR Starjemza [™] (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:

- | | |
|---|--|
| <input type="checkbox"/> adalimumab-adbm (Boehringer Ingelheim)
OR Hadlima [®] (adalimumab-bwwd) | <input type="checkbox"/> Enbrel [®] |
|---|--|

Non-Radiographic Axial Spondyloarthritis

- Member is 18 years of age or older
- Member has a diagnosis of active non-radiographic axial spondyloarthritis
- Member has objective signs of inflammation

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 notes.****