AvMed

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 1-305-671-0200**. 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® (ixekizumab)

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

Member Name: _____

Member AvMed #: _____ **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 Form/Strength: _____

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

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

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

NOTE: The Health Plan considers the use of concomitant therapy with more than one biologic immunomodulator (e.g., Dupixent, Entyvio, Humira, Rinvoq, Stelara) prescribed for the same or different indications to be experimental and investigational. Safety and efficacy of these combinations has **NOT** been established and will **NOT** be permitted.

- ❑ Will the member be discontinuing a previously prescribed biologic if approved for requested medication?
  ❑ Yes **OR** ❑ No
- ❑ If yes, please list the medication that will be discontinued and the medication that will be initiated upon approval along with the corresponding effective date.
  Medication to be discontinued: _____ **Effective date:** _____
  Medication to be initiated: _____ **Effective date:** _____

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. **Check the diagnosis below that applies.**

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❑ Diagnosis: Moderate-to-Severe Plaque Psoriasis

Dosing:

Adults: SubQ: **Initial:** 160 mg once, followed by 80 mg at weeks 2, 4, 6, 8, 10, and 12. **Maintenance:** 80 mg every 4 weeks

Pediatrics:

Children ≥ 6 years and Adolescents <18 years:

- **< 25 kg:** SubQ: 40 mg once, followed by 20 mg every 4 weeks
- **25 to 50 kg:** SubQ: 80 mg once, followed by 40 mg every 4 weeks
- **≥ 50 kg:** SubQ: 160 mg once (administered as 2 separate 80 mg injections), followed by 80 mg every 4 weeks

- ❑ Member is ≥ 6 years of age and has a diagnosis of moderate-to-severe **plaque psoriasis**
- ❑ Prescribed by or in consultation with a **Dermatologist**
- ❑ Member meets **ONE** of the following:
  - ❑ Member tried and failed at least **ONE** of either Phototherapy or Alternative Systemic Therapy for at least **three (3) months**, unless member has a contraindication or intolerance to both phototherapy and alternative systemic therapies **(check each tried below)**:

❑ **Phototherapy:**	❑ **Alternative Systemic Therapy:**
❑ **UV Light Therapy**	❑ **Oral Medications**
❑ NB UV-B	❑ acitretin
❑ PUVA	❑ methotrexate
	❑ cyclosporine

  - ❑ Member has tried and failed another biologic medication other than the requested medication (e.g., adalimumab, Otezla, ustekinumab)

❑ Diagnosis: Active Psoriatic Arthritis

Dosing: SubQ: 160 mg once, followed by 80 mg every 4 weeks

- ❑ Member has a diagnosis of active **psoriatic arthritis**
- ❑ Prescribed by or in consultation with a **Rheumatologist or Dermatologist**
- ❑ Member meets **ONE** of the following:
  - ❑ Member has tried and failed at least **ONE** of the following **DMARD** therapies for at least **three (3) months**:
    - ❑ cyclosporine
    - ❑ leflunomide
    - ❑ methotrexate
    - ❑ sulfasalazine
  - ❑ Member has previously tried and failed another biologic medication other than the requested medication (e.g., adalimumab, Otezla, Skyrizi)

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❑ Diagnosis: Active Ankylosing Spondylitis

Dosing: SubQ: 160 mg once, followed by 80 mg every 4 weeks

- ❑ Member has a diagnosis of active **ankylosing spondylitis**
- ❑ Prescribed by or in consultation with a **Rheumatologist**
- ❑ Member tried and failed, has a contraindication, or intolerance to **ONE** NSAID

❑ Diagnosis: Active Non-radiographic Axial Spondyloarthritis

Dosing: SubQ: 80 mg every 4 weeks

- ❑ Member has a diagnosis of active **non-radiographic axial spondyloarthritis**
- ❑ Prescribed by or in consultation with a **Rheumatologist**
- ❑ Member has at least **ONE** of the following objective signs of inflammation:
  - ❑ C-reactive protein [CRP] levels above the upper limit of normal
  - ❑ Sacroiliitis on magnetic resonance imaging [MRI] (indicative of inflammatory disease, but without definitive radiographic evidence of structural damage on sacroiliac joints)
- ❑ Member tried and failed, has a contraindication, or intolerance to **TWO** NSAIDs

Medication being provided by a Specialty Pharmacy – Proprium Rx

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.

***Approved by Pharmacy and Therapeutics Committee**: ~~7/21/2016; 3/26/2026;~~ **9/24/2026**
REVISED/REFORMATTED/UPDATED: ~~9/22/2016; 12/11/2016; 8/5/2017; 12/28/2017; 3/14/2018; 6/27/2018; 11/23/2018; 9/7/2019; 11/27/2019; 11/19/2020; 5/10/2022; 6/13/2022; 6/24/2022; 12/21/2022; 10/27/2023;~~ **8/6/2026**