PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Taltz (Ixekizumab)

Phone: 800-728-7947 Fax back to: 866-880-4532

The Scott & White Health Plan Pharmacy Department manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:	**Prescriber Name:** **Supervising Physician:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. What diagnosis is this drug being prescribed for (pick one)?

☐ Plaque Psoriasis ☐ Other

Q2. Please provide ICD code for diagnosis.

Q3. Please indicate location of administration.

☐ Home
☐ Long Term Care (LTC) facility
☐ Physician office (drug from office stock)
☐ Physician office (drug from pharmacy with a prescription)

Q4. Is the prescriber a Dermatologist?

☐ Yes ☐ No

Q5. Does the patient have moderate to severe plaque psoriasis affecting greater than 10% of body surface area (BSA)?

☐ Yes ☐ No

Q6. Does the patient have moderate to severe plaque psoriasis affecting crucial body areas such as hands, feet, face,

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or genitals?

☐ Yes ☐ No

Q7. Has the patient failed at least TWO TOPICAL treatments [including but not limited to corticosteroids, Vitamin D analogues, Vitamin D analogue/corticosteroid combinations, Tazorac® (tazarotene)]?

☐ Yes ☐ No

Q8. Has the patient failed or does the patient have a contraindication to phototherapy (UVB or PUVA)?

☐ Yes ☐ No

Q9. Has the patient failed or does the patient have a contraindication to methotrexate, cyclosporine, acitretin, leflunomide, sulfasalazine, OR tacrolimus?

☐ Yes ☐ No

Q10. Please select all of the following agents that the patient has failed, has an intolerance or contraindication to:

- ☐ Humira
- ☐ Enbrel
- ☐ Cosentyx
- ☐ Remicade
- ☐ Stelara
- ☐ Other

Q11. Additional comments

Prescriber Signature

Date

□ Expedited/Urgent - By checking this box and signing above, I certify that applying the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function

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Lack of the necessary documentation may result in a medical necessity denial. Requesting providers may speak to the SWHP medical director at 1-888-316-7947 regarding the case to have an opportunity to help impact the decision on a request before coverage has been decided.