OPTIMA HEALTH PLAN

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. Incomplete form will delay authorization process.***

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

DRUG INFORMATION: Complete information below. If incomplete, authorization process will be delayed

Drug Form/Strength: _____

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

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

RECOMMENDED DOSE:

160mg (two 80mg injections) at Week 0; followed by 80mg at weeks 2, 4, 6, 8, 10, and 12; then 80mg every 4 weeks

CLINICAL CRITERIA: ALL boxes MUST be checked to qualify. Incomplete information will delay authorization process.

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

Diagnosis*: *Moderate to Severe Chronic Plaque Psoriasis

❑ Patient tried and failed ***at least one*** of either Phototherapy or Alternative Systemic Therapy for ***at least three (3) months (check each tried)***:

❑ **Phototherapy** **OR** ❑ **Alternative Systemic Therapy**

❑ **UV Light Therapy**
- ❑ NB UV-B
- ❑ PUVA

❑ **Oral Alternative Systemic Therapy**
- ❑ acitretin
- ❑ methotrexate
- ❑ cyclosporine

AND

❑ **Trial and failure of two (2) of the *PREFERRED* Biologics below:**

❑ Humira®	❑ Stelara®
❑ Cosentyx®	❑ Tremfya™

Check Device to be used:

❑ Auto-Injection or prefilled: 80 mg/mL solution in a single-use

***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.****

Patient Name: _____

Member Optima #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

***Approved by Pharmacy and Therapeutics Committee**: 7/21/2016
Revised/Updated: ~~9/22/2016; 12/11/2016; 8/5/2017;~~ **12/28/2017**;