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 all information below or 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**

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

OR

❑ **Alternative Systemic Therapy**

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

AND

❑ **Trial and failure of one (1) of the PREFERRED Biologics below:**

❑ **Humira®**	❑ **Stelara®**
❑ **Cimzia®**	❑ **Tremfya™**

AND

❑ **Cosentyx®**

(continued on next page)

❑ Diagnosis: Active Psoriatic Arthritis

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

❑ **Humira®**	❑ **Stelara®**
❑ **Cimzia®**	❑ **Simponi®**

AND

❑ **Both Cosentyx® and Xeljanz®/Xeljanz XR®**

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; 3/14/2018; 6/27/2018;~~ **11/23/2018**;