

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)*:

- | | | |
|--|----|--|
| <input type="checkbox"/> Phototherapy | OR | <input type="checkbox"/> Alternative Systemic Therapy |
| <input type="checkbox"/> UV Light Therapy | | <input type="checkbox"/> Oral Alternative Systemic Therapy |
| <input type="checkbox"/> NB UV-B | | <input type="checkbox"/> acitretin |
| <input type="checkbox"/> PUVA | | <input type="checkbox"/> methotrexate |
| | | <input type="checkbox"/> cyclosporine |

AND

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

<input type="checkbox"/> Humira®	<input type="checkbox"/> Stelara®
<input type="checkbox"/> Cosentyx®	<input type="checkbox"/> Tremfya™

Diagnosis: Active Psoriatic Arthritis

Patient must have tried and failed at least one of the following medications:

<input type="checkbox"/> Humira®	<input type="checkbox"/> Stelara®
<input type="checkbox"/> Cimzia®	<input type="checkbox"/> Simponi®

Check Device to be used:

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

(signature continued on next page)

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