Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
Taltz (ixekizumab) Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk
Length of Authorization: 12 months

Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **Taltz (ixekizumab).** Please complete all sections, incomplete forms will delay processing. Fax this form back to Kaiser Permanente within 24 hours fax: 1-866-331-2104. If you have any questions or concerns, please call 1-866-331-2103. **Requests will not be considered unless this form is complete. The KP-MAS Formulary can be found at:**
http://www.providers.kaiserpermanente.org/mas/formulary.html

1 – Patient Information

Patient Name: _____ Kaiser Medical ID#: _____ Date of Birth: _____

2 – Provider Information

Provider Name: _____ Specialty: _____ Provider NPI: _____

Provider Address: _____

Provider Phone #: _____Provider Fax #: _____

Please check the boxes that apply:
□ Initial Request □ Continuation of Therapy Request

3 – Pharmacy Information

Pharmacy Name: _____ Pharmacy NPI: _____

Pharmacy Phone #_____ Pharmacy Fax #: _____

4 – Drug Therapy Requested

Drug 1: Name/Strength/Formulation: _____
Sig: _____

Drug 2: Name/Strength/Formulation: _____
Sig: _____

5– Diagnosis/Clinical Criteria

1. Does the member have diagnosis of one of the following? **AND**
   □ Psoriatic arthritis (PsA)

   □ Ankylosing Spondylitis (AS)

   □ Plaque Psoriasis (PsO) adults and children 6 years of age or older who are candidates for systemic therapy or phototherapy

   □ Non-Radiographic spondyloarthritis (nr-axSpA)

   □ Other: _____

2. Was there therapeutic failure on oral methotrexate? **AND**
   □ No □ Yes

3. Was there therapeutic failure to one of the preferred agents? (e.g. Enbrel, Humira) **AND**
   □ No □ Yes

4. If this is being used for Plaque Psoriasis:
   a. Was there therapeutic failure on at least 2 topical psoriasis agents (e.g. corticosteroids, calcipotriene, coal tar, tazarotene, or anthralin, etc.)?
      □ No □ Yes

   b. Is the patient's age ≥ 6 years
      □ No □ Yes

6 – Provider Sign-Off

Additional Information – Please provide any additional information that should be taken into consideration.

_____

I certify that the information provided is accurate. Supporting documentation is available for State audits.

Provider Signature:	**Date:**