

PRIOR AUTHORIZATION REQUEST FORM

Taltz

For authorization, please answer each question and fax this form PLUS chart notes back to RealRx Medicaid Prior Authorization Department at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call Pharmacy Customer Service for assistance.

- Healthy U: 855-856-5694
- Healthy U CHIP: 855-203-3633
- Health Choice Utah: 855-864-1404

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:

Height/Weight:

Product Requested: Taltz (ixekizumab)

Directions for Use: _____

PART I: Criteria for Approval: (All of the following criteria must be met) - Then move to PART II

	Yes	No
1. Is the medication being prescribed by or in consultation with a provider specializing in the disease treatment?	<input type="checkbox"/>	<input type="checkbox"/>
2. Does the patient have any of the following diagnoses? (check the applicable) <input type="checkbox"/> Ankylosing Spondylitis (AS) <input type="checkbox"/> Non-radiographic Axial Spondyloarthritis (nr-axSpA) <input type="checkbox"/> Plaque Psoriasis (PsO) <input type="checkbox"/> Psoriatic Arthritis (PsA) <input type="checkbox"/> Other - Off Label or Compendia Use (specify): _____	<input type="checkbox"/>	<input type="checkbox"/>
3. Does the provider attest that the patient is not taking concurrent treatment or that the medication will not be used in combination with other TNF-inhibitor, biologic response modifier or other biologic DMARDs, Janus kinase Inhibitors, or Phosphodiesterase 4 inhibitor (i.e., apremilast, tofacitinib, baricitinib) as verified by prescriber attestation, member medication fill history, or submitted documentation?	<input type="checkbox"/>	<input type="checkbox"/>
4. Does the requested medication and diagnosis follow FDA-approved age, dosing, monitoring and contraindications? If answer is No, go to Part II, section 5	<input type="checkbox"/>	<input type="checkbox"/>
5. Has the patient tried and failed, demonstrated an intolerance to, or has a contraindication to the preferred TNF, if applicable?	<input type="checkbox"/>	<input type="checkbox"/>

PART II: Select and fill out applicable sections:

Section 1: Additional criteria for Ankylosing Spondylitis (AS) (All of the following criteria must be met)

1. Is the patient at least 18 years of age or older?	<input type="checkbox"/>	<input type="checkbox"/>
2. Does the patient have a diagnosis of Ankylosing Spondylitis demonstrated by description of baseline symptoms present in the chart notes?	<input type="checkbox"/>	<input type="checkbox"/>

Section 2: Additional criteria for Non-radiographic Axial Spondyloarthritis (nr-axSpA) (All of the following criteria must be met)

1. Is the patient at least 18 years of age or older?	<input type="checkbox"/>	<input type="checkbox"/>
2. Does the patient have a diagnosis of active non-radiographic axial spondyloarthritis (nr-axSpA) with objective signs of inflammation demonstrated by description of baseline symptoms present in the chart notes?	<input type="checkbox"/>	<input type="checkbox"/>

Section 3: Additional criteria for Plaque Psoriasis (PsO) (All of the following criteria must be met)		
1. Is the patient at least 6 years of age or older?	<input type="checkbox"/>	<input type="checkbox"/>
2. Has the patient been diagnosed with moderate to severe plaque psoriasis involving greater than 3% body surface area?	<input type="checkbox"/>	<input type="checkbox"/>
3. If less than 3% of the body is involved, is there scalp, palmar, foot, or groin involvement causing significant disability?	<input type="checkbox"/>	<input type="checkbox"/>
Section 4: Additional criteria for Psoriatic Arthritis (PsA) (All of the following criteria must be met)		
1. Is the patient at least 18 years of age or older?	<input type="checkbox"/>	<input type="checkbox"/>
2. Does the patient have a diagnosis of active psoriatic arthritis demonstrated by description of baseline symptoms present in the chart notes?	<input type="checkbox"/>	<input type="checkbox"/>
Section 7: Other - Off Label or Compendia Use of FDA-Approved Drugs Additional Criterion:		
1. Does the clinical documentation show an adequate trial and failure with at least ONE FDA-labeled and Medicaid preferred medication, if applicable?	<input type="checkbox"/>	<input type="checkbox"/>
2. Provider attest the requested drug is being used for a medically accepted indication that is supported by information from the appropriate compendia* of current literature. Including at least (1) major multi-site study or three (3) smaller studies published in JAMA, NEJM, Lancet, or other peer review specialty medical journals in the most recent years? * Compendia use must be recommended by generally accepted compendia such as American Hospital Formulary Service Drug Information (AHFS), United States Pharmacopeia-Drug Information (USP-DI), the Micromedex Information System, Pediatric and Neonatal Lexi-Drugs, or clinical guidelines.	<input type="checkbox"/>	<input type="checkbox"/>
Reauthorization		
1. Has the provider submitted an updated letter with medical justification and updated chart notes demonstrating positive clinical response?	<input type="checkbox"/>	<input type="checkbox"/>

Initial Authorization: Up to six (6) months

Reauthorization: Up to one (1) year

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Policy: PHARM-HYB-189

Origination Date: 01/01/2026

Reviewed/Revised Date:

Next Review Date:

Current Effective Date: 01/01/2026

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