TRICARE Prior Authorization Request Form for
ixekizumab **(Taltz)**

JOHNS HOPKINS
HEALTH PLANS
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FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

USFHP Pharmacy Prior Authorization Form

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Step 1 **Please complete patient and physician information** (please print):

Patient Name: _____ Physician Name: _____

Address: _____ Address: _____

_____ _____

Sponsor ID # _____ Phone #: _____

Date of Birth: Secure Fax #:

Step 2 **Please complete the clinical assessment:**

1. What is the patient's age?	☐ 18 years of age or older – proceed to question **2** ☐ 6 years of age to less than 18 years of age – proceed to question **3** ☐ Younger than 6 years of age – **STOP Coverage not approved**	
2. What is the indication or diagnosis in this adult patient?	☐ Active **psoriatic arthritis** – proceed to question **4** ☐ Moderate to severe **plaque psoriasis** in a patient who is a candidate for systemic therapy or phototherapy. – proceed to question **4** ☐ Active **ankylosing spondylitis** (AS) – proceed to question **4** ☐ Active **non-radiographic axial spondyloarthritis (nr-axSpA)** with objective signs of inflammation – proceed to question **4** ☐ Other indication or diagnosis – **STOP Coverage not approved.**	
3. What is the indication or diagnosis in this pediatric patient?	☐ Moderate to severe plaque psoriasis who are candidates for systemic therapy or phototherapy – proceed to question **4** ☐ Other indication or diagnosis – **STOP Coverage not approved.**	
4. Humira is the Department of Defense's preferred targeted biologic agent. Has the patient tried Humira?	☐ Yes proceed to question **5**	☐ No proceed to question **7**

5. Has the patient had an inadequate response to Humira?	☐ Yes proceed to question **8**	☐ No proceed to question **6**
6. Has the patient experienced an adverse reaction to Humira that is not expected to occur with the requested agent?	☐ Yes proceed to question **8**	☐ No proceed to question **7**
7. Does the patient have a contraindication to Humira (adalimumab)?	☐ Yes proceed to question **8**	☐ No **STOP** **Coverage not approved**
8. Has the patient tried and experienced an inadequate response to Cosentyx (secukinumab)?	☐ Yes proceed to question **11**	☐ No proceed to question **9**
9. Has the patient experienced an adverse reaction to Cosentyx (secukinumab) that is not expected to occur with the requested agent?	☐ Yes proceed to question **11**	☐ No proceed to question **10**
10. Does the patient have a contraindication to Cosentyx (secukinumab)?	☐ Yes proceed to question **11**	☐ No **STOP** **Coverage not approved**
11. What is the requested medication being used for?	☐ Ankylosing spondylitis (AS) – proceed to question **12** ☐ Non-radiographic axial spondyloarthritis (nr-axSpA) – proceed to question **12** ☐ Other indication or diagnosis – proceed to question **13**	
12. Has the patient had an inadequate response to at least two NSAIDs over a period of at least two months?	☐ Yes proceed to question **17**	☐ No **STOP** **Coverage not approved**
13. Has the patient tried and experienced an inadequate response to Stelara (ustekinumab)?	☐ Yes proceed to question **16**	☐ No proceed to question **14**
14. Has the patient experienced an adverse reaction to Stelara (ustekinumab) that is not expected to occur with the requested agent?	☐ Yes proceed to question **16**	☐ No proceed to question **15**
15. Does the patient have a contraindication to Stelara (ustekinumab)?	☐ Yes proceed to question **16**	☐ No **STOP** **Coverage not approved**
16. Has the patient had an inadequate response to non-biologic systemic therapy? (For example: methotrexate, aminosalicylates [such as, sulfasalazine, mesalamine], corticosteroids, immunosuppressants [for example., azathioprine], etc.)	☐ Yes proceed to question **17**	☐ No **STOP** **Coverage not approved**

17. Does the patient have evidence of a negative TB test result in the past 12 months (or TB is adequately managed)?	☐ Yes proceed to question **18**	☐ No **STOP** **Coverage not approved**
18. Will the patient be receiving other targeted immunomodulatory biologics with the requested medication including but not limited to the following: Actemra, Cimzia, Cosentyx, Enbrel, Humira, Ilumya, Kevzara, Kineret, Olumiant, Orencia, Otezla, Remicade, Rinvoq ER, Rituxan, Siliq, Simponi, Skyrizi, Stelara, Tremfya or Xeljanz/Xeljanz XR?	☐ Yes **STOP** **Coverage not approved**	☐ No **Sign and date below**

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

_____ _____
Prescriber Signature Date

[02 Oct 2024]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: