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

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE
7231 Parkway Drive, Suite 100, Hanover, MD 21076

USFHP Pharmacy Prior Authorization Form

FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

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. **Humira is the Department of Defense's preferred targeted biologic agent. Has the patient tried Humira?**	☐ Yes proceed to question **2**	☐ No proceed to question **4**
2. **Has the patient had an inadequate response to Humira?**	☐ Yes proceed to question **5**	☐ No proceed to question **3**
3. **Has the patient experienced an adverse reaction to Humira that is not expected to occur with the requested agent?**	☐ Yes proceed to question **5**	☐ No **STOP** **Coverage not approved**
4. **Does the patient have a contraindication to Humira (adalimumab)?**	☐ Yes proceed to question **5**	☐ No **STOP** **Coverage not approved**
5. **Has the patient tried and experienced an inadequate response, had an adverse reaction, or have a contraindication to Cosentyx (secukinumab)?**	☐ Yes proceed to question **6**	☐ No **STOP** **Coverage not approved**
6. **Has the patient tried and experienced an inadequate response, had an adverse reaction, or have a contraindication to Stelara (ustekinumab)?**	☐ Yes proceed to question **8**	☐ No proceed to question **7**
7. **Is the requested medication being used for Active ankylosing spondylitis (AS)?**	☐ Yes proceed to question **8**	☐ No **STOP** **Coverage not approved**
8. **Is the patient greater than or equal to 18 years of age?**	☐ Yes proceed to question **9**	☐ No **STOP** **Coverage not approved**

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9. What is the indication or diagnosis in this adult patient?	☐ Active **psoriatic arthritis** – Proceed to question **10** ☐ Moderate to severe active **plaque psoriasis** in a patient who is a candidate for systemic therapy or phototherapy. – Proceed to question **10** ☐ Active ankylosing spondylitis (AS)– Proceed to question **10** ☐ Other indication or diagnosis – **STOP: Coverage not approved.**	
10. Has the patient had an inadequate response to non-biologic systemic therapy? (For example: methotrexate, aminosalicylates [e.g. sulfasalazine, mesalamine], corticosteroids, immunosuppressants [e.g. azathioprine], etc.)	☐ Yes proceed to question **11**	☐ No **STOP** **Coverage not approved**
11. 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 **12**	☐ No **STOP** **Coverage not approved**
12. Will the patient be receiving other targeted immunomodulatory biologics with Taltz including but not limited to the following: Actemra, Cimzia, Cosentyx, Enbrel, Humira, Ilumya, Kevzara, Kineret, Olumiant, Orencia, Otezla, Remicade, Rinvoq, 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

[08 April 2020]

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