AvMed

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 1-305-671-0200**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: Taltz® SQ (ixekizumab)

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member AvMed #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight: _____ **Date:** _____

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied. **Check the diagnosis below that applies.**

❑ Diagnosis: Moderate-to-Severe Chronic Plaque Psoriasis

Dosing:

Adults: SubQ: **Initial:** 160 mg once, followed by 80 mg at weeks 2, 4, 6, 8, 10, and 12. **Maintenance:** 80 mg every 4 weeks

Pediatrics:

Children ≥ 6 years and Adolescents <18 years:

- **< 25 kg:** SubQ: 40 mg once, followed by 20 mg every 4 weeks
- **25 to 50 kg:** SubQ: 80 mg once, followed by 40 mg every 4 weeks
- **≥ 50 kg:** SubQ: 160 mg once (administered as 2 separate 80 mg injections), followed by 80 mg every 4 weeks

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- ❑ Member is ≥ 6 years of age and has a diagnosis of moderate-to-severe **plaque psoriasis**
- ❑ Prescribed by or in consultation with a **Dermatologist**
- ❑ Member tried and failed at least **ONE** of either Phototherapy or Alternative Systemic Therapy for at least **three (3) months** **(check each tried below)**:

❑ **Phototherapy**:	❑ **Alternative Systemic Therapy**:
❑ **UV Light Therapy** ❑ NB UV-B ❑ PUVA	❑ **Oral Medications** ❑ acitretin ❑ methotrexate ❑ cyclosporine

❑ Diagnosis: Active Psoriatic Arthritis

Dosing: SubQ: 160 mg once, followed by 80 mg every 4 weeks

- ❑ Member has a diagnosis of active **psoriatic arthritis**
- ❑ Prescribed by or in consultation with a **Rheumatologist or Dermatologist**
- ❑ Member tried and failed at least **ONE** of the following DMARD therapies for at least **three (3) months**:
  - ❑ methotrexate oral or SQ 15-25 mg/week
  - ❑ leflunomide oral 20 mg/day
  - ❑ sulfasalazine oral 2-3 g/day

❑ Diagnosis: Active Ankylosing Spondylitis

Dosing: SubQ: 160 mg once, followed by 80 mg every 4 weeks

- ❑ Member has a diagnosis of active **ankylosing spondylitis**
- ❑ Prescribed by or in consultation with a **Rheumatologist**
- ❑ Member tried and failed, has a contraindication, or intolerance to **TWO** NSAIDs

❑ Diagnosis: Active Non-radiographic Axial Spondyloarthritis

Dosing: SubQ: 80 mg every 4 weeks

- ❑ Member has a diagnosis of active **non-radiographic axial spondyloarthritis**
- ❑ Prescribed by or in consultation with a **Rheumatologist**

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- ❑ Member has at least **ONE** of the following objective signs of inflammation:
  - ❑ C-reactive protein [CRP] levels above the upper limit of normal
  - ❑ Sacroiliitis on magnetic resonance imaging [MRI] (indicative of inflammatory disease, but without definitive radiographic evidence of structural damage on sacroiliac joints)
- ❑ Member tried and failed, has a contraindication, or intolerance to **TWO** NSAIDs

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.*