BlueCross BlueShield
Federal Employee Program

TALTZ
PRIOR APPROVAL REQUEST

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

Taltz (ixekizumab)

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

NOTE: Form must be completed in its **entirety** for processing

1. Has the patient been on this medication continuously for the last **6 months** excluding samples? ***Please select answer below:***
   ❑ **YES –** this is a PA renewal for **CONTINUATION** of therapy, please answer the questions on **PAGE 3**
   ❑ **NO** – this is **INITIATION** of therapy, please answer the questions below:
2. Is this request for brand or generic? ❑Brand ❑Generic
3. Does the patient have any active infections, including tuberculosis (TB), or hepatitis B virus (HBV)? ❑Yes ❑No
4. Has the patient been tested for latent tuberculosis infections? ❑Yes* ❑ No
   ***If YES,** was the result of the test positive or negative for TB infection? ❑Negative ❑Positive*
   ***If POSITIVE**, has the patient completed treatment or is the patient currently receiving treatment for latent TB? ❑Yes ❑No
5. Does the prescriber agree to monitor for onset or exacerbations of Crohn's or ulcerative colitis and discontinue if necessary? ❑Yes ❑No
6. Will the patient be given live vaccines while on this therapy? ❑Yes ❑No
7. Will Taltz be used in combination with another biologic DMARD or targeted synthetic DMARD? ❑Yes* ❑No
   ***If YES**, please specify medication: _____
   DMARDs: Actemra, Avsola, Cimzia, Cosentyx, Enbrel, Entyvio, Humira, Ilumya, Inflectra, Kevzara, Kineret, Olumiant, Orencia, Otezla, Remicade, Renflexis, Riabni, Rinvoq, Rituxan, Ruxience, Siliq, Simponi/Simponi Aria, Skyrizi, Sotyktu, Spevigo, Stelara, Tremfya, Truxima, Xeljanz/Xeljanz XR
8. What is the patient's diagnosis?
   ❑Active ankylosing spondylitis (AS)
   a. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to at least two non-steroidal anti-inflammatory drugs (NSAIDs)? ❑Yes ❑No
   b. **Age 18 or Older:** Does the prescriber agree not to exceed the FDA labeled maintenance dose of 80mg every 4 weeks? ❑Yes ❑No
   c. **Standard/Basic Option, for claims adjudicated through the pharmacy benefit:** Is this medication being requested as a change from one of the following to allow the member access to their copay benefit: Bimzelx, Cimzia, Cosentyx, Simponi, or Xeljanz/XR? ❑Yes* ❑No
      ***If YES**, please select medication: ❑Bimzelx ❑Cimzia ❑Cosentyx ❑Simponi ❑Xeljanz/Xeljanz XR

PLEASE PROCEED TO PAGE 2 FOR ADDITIONAL DIAGNOSES

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PAGE 2 - PHYSICIAN COMPLETES

Patient Name: _____ **DOB:** _____ **Patient ID: R** _____

❑Active psoriatic arthritis (PsA)

a. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to a three month trial of at least one conventional DMARD? ❑Yes ❑No

b. **Age 18 or Older:** Does the prescriber agree not to exceed the FDA labeled maintenance dose of 80mg every 4 weeks? ❑Yes ❑No

c. **Standard/Basic Option patient, <u>for claims adjudicated through the pharmacy benefit</u>:** Is this medication being requested as a change from one of the following to allow the member access to their copay benefit: Bimzelx, Cimzia, Cosentyx, Orencia SC, or Simponi? ❑Yes* ❑No

If YES, please select medication: ❑Bimzelx ❑Cimzia ❑Cosentyx ❑Orencia SC ❑Simponi

❑Moderate to severe plaque psoriasis (PsO)

a. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to conventional systemic therapy? ***Please select answer below:***

❑Inadequate response ❑Intolerance or contraindication ❑Has not tried conventional systemic therapy

b. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to phototherapy?

❑Inadequate response ❑Intolerance or contraindication ❑Has not tried phototherapy

c. **Age 6-17**: What is the patient's weight? ***Please select answer below:***

❑**Less than 25kg (55lbs)**: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 20mg every 4 weeks? ❑Yes ❑No

❑**25kg (55lbs) to 50kg (110lbs)**: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 40mg every 4 weeks? ❑Yes ❑No

❑**Greater than 50kg (110lbs)**: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 80mg every 4 weeks? ❑Yes ❑No

d. **Age 18 or Older:** Does the prescriber agree not to exceed the FDA labeled maintenance dose of 80mg every 4 weeks? ❑Yes ❑No

e. **Standard/Basic Option patient, <u>for claims adjudicated through the pharmacy benefit</u>:** Is this medication being requested as a change from one of the following to allow the member access to their copay benefit: Bimzelx, Cimzia, Cosentyx, Ilumya, Siliq, or Sotyktu? ❑Yes* ❑No

If YES, please select medication: ❑Bimzelx ❑Cimzia ❑Cosentyx ❑Ilumya ❑Siliq ❑Sotyktu

❑Non-radiographic axial spondyloarthritis (nr-axSpA)

a. Does the patient have objective signs of inflammation? ❑Yes ❑No

b. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to at least two non-steroidal anti-inflammatory drugs (NSAIDs)? ❑Yes ❑No

c. **Age 18 or Older:** Does the prescriber agree not to exceed the FDA labeled maintenance dose of 80mg every 4 weeks? ❑Yes ❑No

d. **Standard/Basic Option patient, <u>for claims adjudicated through the pharmacy benefit</u>:** Is this medication being requested as a change from Bimzelx or Cosentyx to allow the member access to their copay benefit? ❑Yes* ❑No

If YES, please select medication: ❑Bimzelx ❑Cosentyx

❑ Other **(*please specify*):** _____

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Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

CONTINUATION OF THERAPY (PA RENEWAL)

Taltz (ixekizumab)

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

NOTE: Form must be completed in its **entirety** for processing

1. Has the patient been on this medication continuously for the last **6 months** excluding samples? ***Please select answer below:***
   ❑**NO** – this is **INITIATION** of therapy, please answer the questions on **PAGE 1**
   ❑**YES –** this is a PA renewal for **CONTINUATION** of therapy, please answer the questions below:
2. Is this request for brand or generic? ❑Brand ❑Generic
3. What is the patient's diagnosis?
   ❑Ankylosing spondylitis (AS)
   ❑Non-radiographic axial spondyloarthritis (nr-axSpA)
   ❑Plaque psoriasis (PsO)
   a. **Age 6-17:** What is the patient's weight? ***Please select answer below:***
   ❑**Less than 25kg (55lbs)**: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 20mg every 4 weeks? ❑Yes ❑No
   ❑**25kg (55lbs) to 50kg (110lbs)**: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 40mg every 4 weeks? ❑Yes ❑No
   ❑**Greater than 50kg (110lbs)**: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 80mg every 4 weeks? ❑Yes ❑No
   ❑Psoriatic arthritis (PsA)
   ❑Other ***(please specify)***: _____
4. **Age 18 or Older:** Does the prescriber agree not to exceed the FDA labeled maintenance dose of 80mg every 4 weeks? ❑Yes ❑No
5. Has the patient's condition improved or stabilized with therapy? ❑Yes ❑No
6. Does the prescriber agree to monitor for onset or exacerbations of Crohn's or ulcerative colitis and to discontinue therapy if necessary? ❑Yes ❑No
7. Will the patient be given live vaccines while on this therapy? ❑Yes ❑No
8. Will Taltz be used in combination with another biologic DMARD or targeted synthetic DMARD? ❑Yes* ❑No
   If YES, please specify medication: _____
   ****DMARDs: Actemra, Avsola, Cimzia, Cosentyx, Enbrel, Entyvio, Humira, Ilumya, Inflectra, Kevzara, Kineret, Olumiant, Orencia, Otezla, Remicade, Renflexis, Riabni, Rinvoq, Rituxan, Ruxience, Siliq, Simponi/Simponi Aria, Skyrizi, Sotyktu, Spevigo, Stelara, Tremfya, Truxima, Xeljanz/ Xeljanz XR***