

BlueShield. TALTZ
Federal Employee Program. PRIOR APPROVAL REQUEST

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

Attn. Clinical Services Fax: 1-877-378-4727

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.

Patient Information (required)			Provider Information (required)			
Date:			Provider Name:			
Patient Name:						
Date of Birth: Sex: □Male □Female			Office Fax:			
Street Address: Office Street Address:						
ate: Zip:	City:	State:	Zip:			
1 1 1 1	Physician Signature:	l l				
PHYSICIAN	N COMPLETES					
NOTE: Form must be completion continuously for the lacontinuously for the lacontinuously for the rapy, please answer the quantum continuously for the second continuously	rm which medication is part of letted in its entirety for process to months excluding sappy, please answer the que	essing amples? <i>Please select a</i>	enswer below:			
Brand □ Generic						
fections, including tubercul	osis (TB), or hepatitis B	virus (HBV)? □Yes	□No			
at positive or negative for T	B infection? □Negative		ent TB? □Yes □No			
for onset or exacerbations of	Crohn's or ulcerative coli	tis and discontinue if neo	cessary? □Yes □No			
Will the patient be given live vaccines while on this therapy? □Yes □No						
	Taltz (Tepblue.org/formulary to confine NOTE: Form must be completed to continuously for the lagraphy, please answer the quality please answer the	Provider Name: Specialty: Office Phone: Office Street Address: ate: Zip: Physician Signature: PHYSICIAN COMPLETES Taltz (ixekizumab) Afepblue.org/formulary to confirm which medication is part of the last 6 months excluding sation continuously for the last 6 months excluding sation continuously for the last 6 months excluding sation continuously for the questions below: OBRAND Generic fections, including tuberculosis (TB), or hepatitis By the tuberculosis infections? Tyes* No st positive or negative for TB infection? Negative int completed treatment or is the patient currently recompleted or exacerbations of Crohn's or ulcerative colinger.	Provider Name: Specialty: Office Phone: Office Fax Office Street Address: ate: Zip: City: Physician Signature: PHYSICIAN COMPLETES Taltz (ixekizumab) Afepblue.org/formulary to confirm which medication is part of the patient's benefit NOTE: Form must be completed in its entirety for processing ation continuously for the last 6 months excluding samples? Please select at a continuously for the questions below: CONTINUATION of therapy, please answer the questions on PAGE 3 Berapy, please answer the questions below: CONTINUATION of therapy are answer the questions on PAGE 3 Berapy, please answer the questions below: Continuously for the last 6 months excluding samples? Please select at the continuously for the patient on the patient on the patient on the patient of the patient of the patient of the patient of the patient currently receiving treatment for late for onset or exacerbations of Crohn's or ulcerative colitis and discontinue if near the patient currently receiving treatment for late for onset or exacerbations of Crohn's or ulcerative colitis and discontinue if near the patient currently receiving treatment for late for onset or exacerbations of Crohn's or ulcerative colitis and discontinue if near the patient currently receiving treatment for late for onset or exacerbations of Crohn's or ulcerative colitis and discontinue if near the patient currently receiving treatment or late for onset or exacerbations of Crohn's or ulcerative colitis and discontinue if near the patient currently receiving treatment or late for onset or exacerbations of Crohn's or ulcerative colitis and discontinue if near the patient currently receiving treatment or late for the patient currently rece			

8. What is the patient's diagnosis?

□Active ankylosing spondylitis (AS)

**If YES*, please specify medication:

Tremfya, Truxima, Xeljanz/Xeljanz XR

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)?

No

*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,

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

7. Will Taltz be used in combination with another biologic DMARD or targeted synthetic DMARD? □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? \(\textstyre{\texts

*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	.)		
	intolerance or contraindication or ntional DMARD? □Yes □No	have they had an inadequate	treatment response to a three month
b. Age 18 or Older: Does t weeks? □Yes □No	the prescriber agree not to exceed	he FDA labeled maintenance	e dose of 80mg every 4
requested as a change fro	patient, for claims adjudicated to me one of the following to allow the Simponi? \(\textstyle \te		
*If YES, please select	medication: □Bimzelx □Cimz	ia □Cosentyx □Orenc	ia SC □Simponi
☐ Moderate to severe plaque pso			
systemic therapy? Please	select answer below:	have they had an inadequate	treatment response to conventional
☐Inadequate response	☐Intolerance or contraindication	on Has not tried convent	ional systemic therapy
b. Does the patient have an Inadequate response		•	treatment response to phototherapy nerapy
	tient's weight? <i>Please select answe</i> : Does the prescriber agree not to		intenance dose of 20mg every 4
□25kg (55lbs) to 50kg (4 weeks? □Yes □N		not to exceed the FDA labe	led maintenance dose of 40mg every
□Greater than 50kg (1) weeks? □Yes □No		not to exceed the FDA labele	d maintenance dose of 80mg every 4
d. Age 18 or Older: Does tweeks? □Yes □No	the prescriber agree not to exceed	he FDA labeled maintenance	e dose of 80mg every 4
requested as a change fro	patient, <u>for claims adjudicated to</u> mone of the following to allow thor Sotyktu? □Yes* □No		
*If YES, please select	t medication: Bimzelx Cir	nzia □Cosentyx □Ilun	nya □Siliq □Sotyktu
☐Non-radiographic axial spond	lyloarthritis (nr-axSpA)		
a. Does the patient have obj	jective signs of inflammation? \Box	Yes □No	
	intolerance or contraindication or matory drugs (NSAIDs)? □Yes		treatment response to at least two
c. Age 18 or Older: Does t weeks? □Yes □No	he prescriber agree not to exceed t	he FDA labeled maintenance	e dose of 80mg every 4
	patient, for claims adjudicated to m Bimzelx or Cosentyx to allow t		
*If YES, please select medi	ication: Bimzelx Cosenty	X	
☐ Other (please specify):			

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projectan person and eazim and completed form				Fax. 1-011-310-4121			
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:	Sta	te:	Zip:
Patient ID: R	1 1	1 1		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? <i>Please select answer below:</i> □ NO − this is INITIATION of therapy, please answer the questions on <u>PAGE 1</u> □ 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 ever 4 weeks? □Yes □No
	□Greater than 50kg (110lbs): Does the prescriber agree not to exceed the FDA labeled maintenance dose of 80mg every 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

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