Prescriber Criteria Form Taltz 2024 PA Fax 1351-A v1 010124.docx Taltz (ixekizumab) Coverage Determination
This fax machine is located in a secure location as required by HIPAA regulations. Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673**. Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Taltz (ixekizumab).

Drug Name: Taltz (ixekizumab)

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Has the patient previously received the requested drug for any of the following conditions: A) plaque psoriasis, B) psoriatic arthritis, C) ankylosing spondylitis, D) non-radiographic axial spondyloarthritis? [If yes, then no further questions.]	Yes	No
2	Does the patient have a diagnosis of moderate to severe plaque psoriasis? [If no, then skip to question 5.]	Yes	No
3	Does the patient meet one of the following criteria: A) at least 3 percent of body surface area (BSA) is affected by plaque psoriasis at the time of diagnosis, B) crucial body areas (e.g., feet, hands, face, neck, groin, intertriginous areas) are affected by plaque psoriasis at the time of diagnosis? [If no, then no further questions.]	Yes	No
4	Has the patient experienced an inadequate treatment response, intolerance, or does the patient have a contraindication to one of the following products: A) Enbrel (etanercept), B) Humira (adalimumab), C) Otezla (apremilast), D) Skyrizi (risankizumab-rzaa)? [No further questions.]	Yes	No
5	Does the patient have a diagnosis of active psoriatic arthritis? [If no, then skip to question 7.]	Yes	No
6	Has the patient experienced an inadequate treatment response, intolerance, or does the patient have a contraindication to one of the following products: A) Enbrel (etanercept), B)	Yes	No

	Humira (adalimumab), C) Otezla (apremilast), D) Rinvoq (upadacitinib), E) Skyrizi (risankizumab-rzaa), F) Xeljanz (tofacitinib)/Xeljanz XR (tofacitinib extended-release)? [No further questions.]		
7	Does the patient have a diagnosis of active ankylosing spondylitis? [If no, then skip to question 9.]	Yes	No
8	Has the patient experienced an inadequate treatment response, intolerance, or does the patient have a contraindication to one of the following products: A) Enbrel (etanercept), B) Humira (adalimumab), C) Rinvoq (upadacitinib), D) Xeljanz (tofacitinib)/Xeljanz XR (tofacitinib extended-release)? [No further questions.]	Yes	No
9	Does the patient have a diagnosis of active non-radiographic axial spondyloarthritis? [If no, then no further questions.]	Yes	No
10	Has the patient experienced an inadequate treatment response to a non-steroidal anti-inflammatory drug (NSAID) OR does the patient have an intolerance or contraindication to NSAIDs?	Yes	No

Comments:	_____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.

Prescriber (or Authorized) Signature: _____ **Date:**_____