US Family Health Plan
Prior Authorization Request Form for
ixekizumab **(Taltz)**

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be faxed to 855-273-5735

OR

The patient may attach the completed form to the prescription and **mail** it to:
Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? **Call 1-877-880-7007**

Step 1 **Please complete patient and physician information** (please print):

Patient Name:		Physican Name:	
Address:		Address:	
Sponsor ID #		Phone #:	
Date of Birth:		Secure Fax #:	

Step 2 **Please complete the clinical assessment:**

1. What is the patient's age?	☐ 18 years of age or older – proceed to question **2** ☐ 6 years of age to less than 18 years of age proceed to question **3** ☐ Younger than 6 years of age – **STOP** **Coverage not approved**	
2. What is the indication or diagnosis in this adult patient?	☐ Active **psoriatic arthritis** – Proceed to question **4** ☐ Moderate to severe **plaque psoriasis** in a patient who is a candidate for systemic therapy or phototherapy. – Proceed to question **4** ☐ Active **ankylosing spondylitis** (AS) – Proceed to question **4** ☐ Active **non-radiographic axial spondyloarthritis (nr-axSpA)** with objective signs of inflammation AND evidence of elevated CRP and/or MRI evidence of sacroilitis and ASDAS greater or equal to 2.1 – Proceed to question **4** ☐ Other indication or diagnosis – **STOP Coverage not approved.**	
3. What is the indication or diagnosis in this pediatric patient?	☐ Moderate to severe plaque psoriasis who are candidates for systemic therapy or phototherapy– Proceed to question **10** ☐ Other indication or diagnosis – **STOP Coverage not approved.**	
4. Humira is the Department of Defense's preferred targeted biologic agent. Has the patient tried Humira?	☐ Yes proceed to question **5**	☐ No proceed to question **7**
5. Has the patient had an inadequate response to Humira?	☐ Yes proceed to question **8**	☐ No proceed to question **6**
6. Has the patient experienced an adverse reaction to Humira that is not expected to occur with the requested agent?	☐ Yes proceed to question **8**	☐ No **STOP** **Coverage not approved**

7. Does the patient have a contraindication to Humira (adalimumab)?	☐ Yes proceed to question **8**	☐ No **STOP** **Coverage not approved**
8. Has the patient tried and experienced an inadequate response, had an adverse reaction, or have a contraindication to Cosentyx (secukinumab)?	☐ Yes proceed to question **9**	☐ No **STOP** **Coverage not approved**
9. Is the requested medication being used for: • ankylosing spondylitis (AS) or • non-radiographic axial spondyloarthritis (nr-axSpA)	☐ Yes proceed to question **11**	☐ No proceed to question **10**
10. Has the patient tried and experienced an inadequate response, had an adverse reaction, or have a contraindication to Stelara (ustekinumab)?	☐ Yes proceed to question **11**	☐ No **STOP** **Coverage not approved**
11. 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 **12**	☐ No **STOP** **Coverage not approved**
12. 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 **13**	☐ No **STOP** **Coverage not approved**
13. Will the patient be receiving other targeted immunomodulatory biologics with the requested medication including but not limited to the following: Actemra, Cimzia, Cosentyx, Enbrel, Humira, Ilumya, Kevzara, Kineret, Olumiant, Orencia, Otezla, Remicade, Rinvoq ER, 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