

USFHP 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

<https://www.usfamilyhealth.org/for-providers/pharmacy-information/>

Prior Authorization does not expire. Clinical documentation may be required.

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

1	Patient Name: _____	Physician Name: _____
	Address: _____	Address: _____
	Sponsor ID #: _____	Phone #: _____
	Date of Birth: _____	Secure Fax #: _____

Step 2 Please complete the clinical assessment:

2	1. What is the patient's age?	<input type="checkbox"/> 18 years of age or older – proceed to question 2 <input type="checkbox"/> 6 years of age to less than 18 years of age – proceed to question 7 <input type="checkbox"/> Younger than 6 years of age – STOP Coverage not approved	
	2. What is the indication or diagnosis in this adult patient?	<input type="checkbox"/> Active psoriatic arthritis (PsA) – proceed to question 5 <input type="checkbox"/> Moderate to severe plaque psoriasis in a patient who is a candidate for systemic therapy or phototherapy – proceed to question 8 <input type="checkbox"/> Active ankylosing spondylitis (AS) – proceed to question 3 <input type="checkbox"/> Active non-radiographic axial spondyloarthritis (nr-axSpA) with objective signs of inflammation – proceed to question 3 <input type="checkbox"/> Other indication or diagnosis – STOP Coverage not approved.	
	3. Humira is the Department of Defense's preferred targeted biologic agent. Has the patient had an inadequate response to, intolerance to, or contraindication to Humira that is not expected to occur with Taltz?	<input type="checkbox"/> Yes proceed to question 4	<input type="checkbox"/> No STOP Coverage not approved
	4. Has the patient had an inadequate response to at least two NSAIDs over a period of at least two months?	<input type="checkbox"/> Yes proceed to question 9	<input type="checkbox"/> No STOP Coverage not approved

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<p>5. Humira is the Department of Defense’s preferred targeted biologic agent. Has the patient had an inadequate response to, intolerance to, or contraindication to Humira that is not expected to occur with Taltz?</p>	<p align="center"><input type="checkbox"/> Yes proceed to question 6</p>	<p align="center"><input type="checkbox"/> No STOP Coverage not approved</p>
<p>6. Has the patient had an inadequate response, intolerance, or contraindication to non-biologic systemic therapy? (For example: methotrexate, aminosalicylates [such as, sulfasalazine, mesalamine], corticosteroids, immunosuppressants [for example, azathioprine], etc.)</p>	<p align="center"><input type="checkbox"/> Yes proceed to question 9</p>	<p align="center"><input type="checkbox"/> No STOP Coverage not approved</p>
<p>7. What is the indication or diagnosis in this pediatric patient?</p>	<p><input type="checkbox"/> Moderate to severe plaque psoriasis who are candidates for systemic therapy or phototherapy – proceed to question 8</p> <p><input type="checkbox"/> Other indication or diagnosis – STOP Coverage not approved.</p>	
<p>8. Has the patient had an inadequate response, intolerance, or contraindication to non-biologic systemic therapy? (For example: methotrexate, aminosalicylates [such as, sulfasalazine, mesalamine], corticosteroids, immunosuppressants [for example, azathioprine], etc.)</p>	<p align="center"><input type="checkbox"/> Yes proceed to question 9</p>	<p align="center"><input type="checkbox"/> No STOP Coverage not approved</p>
<p>9. Will the patient be receiving other targeted immunomodulatory biologics with the requested medication, including but not limited to the following: TNF inhibitors, IL-1, IL-6, IL-17, IL-23, IL-36, S1p, JAK inhibitors?</p>	<p align="center"><input type="checkbox"/> Yes STOP Coverage not approved</p>	<p align="center"><input type="checkbox"/> No Sign and date below</p>

Step 3 I certify the above is true to the best of my knowledge. Please sign and date:

_____ Prescriber Signature

_____ Date