FUTURE SCRIPTS

Please complete ALL information below and fax your request to 1-888-671-5285

Taltz® Prior Authorization Request Form (Page 1 of 2)

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Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if **generic substitution** is acceptable ❑ Check if request is for **continuation of therapy**	Directions for Use:	

Clinical Information (required)

Select the diagnosis below:

❑ Plaque psoriasis (for example: psoriasis vulgaris, psoriasis; L40.0, L40.8, L40.9)

❑ Psoriatic arthritis (for example: arthropathic psoriasis; L40.5, L40.59)

❑ Other diagnosis: _____ ICD-10 Code(s): _____

Prescriber's Specialty:

Select if Taltz is prescribed by or in consultation with one of the following specialists:

❑ Dermatologist
❑ Rheumatologist

Clinical Information:

Is this request for continuation of prior Taltz therapy? ❑ **Yes** ❑ **No**

Is the patient receiving Taltz in combination with a biologic DMARD (e.g., Enbrel [etanercept], Humira [adalimumab], Cimzia [certolizumab], Simponi [golimumab])? ❑ **Yes** ❑ **No**

Plaque Psoriasis:

Does the patient have moderate to severe active disease? ❑ **Yes** ❑ **No**

Select if the patient has had a trial and failure, contraindication, or intolerance to the following:

❑ Cimzia (certolizumab pegol) ❑ Cosentyx (secukinumab) ❑ Humira (adalimumab)
❑ Skyrizi (risankizumab) ❑ Stelara (ustekinumab) ❑ Tremfya (guselkumab)

Psoriatic Arthritis:

Does the patient have active disease? ❑ **Yes** ❑ **No**

Select if the patient has had a trial and failure, contraindication, or intolerance to the following:

❑ Cimzia (certolizumab pegol) ❑ Cosentyx (secukinumab)
❑ Humira (adalimumab) ❑ Simponi (golimumab)/ Simponi Aria (golimumab IV)
❑ Stelara (ustekinumab) ❑ Xeljanz (tofacitinib) or Xeljanz XR (tofacitinib ER)

Reauthorization:

If this is a reauthorization request, answer the following:

Is there documentation the patient has had a positive clinical response to Taltz therapy? ❑ **Yes** ❑ **No**

Is the patient receiving Taltz in combination with a biologic DMARD (e.g., Enbrel [etanercept], Humira [adalimumab], Cimzia [certolizumab], Simponi [golimumab])? ❑ **Yes** ❑ **No**

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Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.