



Taltz[®] (ixekizumab) Injectable Medication Precertification Request

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(All fields must be completed and legible for Precertification Review.)

Aetna Precertification Notification

Phone: 1-855-240-0535

FAX: 1-877-269-9916

For Medicare Advantage Part B:

FAX: 1-844-268-7263

Please indicate: Start of treatment: Start date ____ / ____ / ____
 Continuation of therapy: Date of last treatment ____ / ____ / ____

Precertification Requested By: _____ Phone: _____ Fax: _____

A. PATIENT INFORMATION

First Name:		Last Name:	
Address:		City:	State: ZIP:
Home Phone:	Work Phone:	Cell Phone:	
DOB:	Allergies:	Email:	
Current Weight: _____ lbs or _____ kgs		Height: _____ inches or _____ cms	

B. INSURANCE INFORMATION

Aetna Member ID #: _____	Does patient have other coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No
Group #: _____	If yes, provide ID#: _____ Carrier Name: _____
Insured: _____	Insured: _____
Medicare: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide ID #: _____	Medicaid: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide ID #: _____

C. PRESCRIBER INFORMATION

First Name:		Last Name:		(Check One): <input type="checkbox"/> M.D. <input type="checkbox"/> D.O. <input type="checkbox"/> N.P. <input type="checkbox"/> P.A.	
Address:		City:	State:	ZIP:	
Phone:	Fax:	St Lic #:	NPI #:	DEA #:	UPIN:
Provider Email:		Office Contact Name:		Phone:	
Specialty (Check one): <input type="checkbox"/> Rheumatologist <input type="checkbox"/> Other: _____					

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration: <input type="checkbox"/> Self-administered <input type="checkbox"/> Physician's Office <input type="checkbox"/> Outpatient Infusion Center Phone: _____ Center Name: _____ <input type="checkbox"/> Home Infusion Center Phone: _____ Agency Name: _____ <input type="checkbox"/> Administration code(s) (CPT): _____ Address: _____	Dispensing Provider/Pharmacy: Patient Selected choice <input type="checkbox"/> Physician's Office <input type="checkbox"/> Retail Pharmacy <input type="checkbox"/> Specialty Pharmacy <input type="checkbox"/> Mail Order <input type="checkbox"/> Other: _____ Name: _____ Address: _____ Phone: _____ Fax: _____ TIN: _____ PIN: _____
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E. PRODUCT INFORMATION

Request is for Taltz: Dose: _____ Frequency: _____

F. DIAGNOSIS INFORMATION – Please indicate primary ICD Code and specify any other where applicable.

Primary ICD Code: _____ Secondary ICD Code: _____ Other ICD Code: _____

G. CLINICAL INFORMATION – Required clinical information must be completed in its entirety for all precertification requests.

For Initiation requests: (Clinical documentation required for all requests)

Yes No Will ixekizumab (Taltz) be given concomitantly with apremilast, tofacitinib, or other biologic DMARDs (e.g., adalimumab, infliximab)?

Yes No Does the patient have a documented TB test within 6 months of initiating biologic therapy?
(check all that apply): PPD test interferon-gamma assay (IGRA) chest x-ray
Please enter the date and results of the TB test: Date: ____ / ____ / ____ Results: Positive Negative Unknown
If positive, does the patient have latent or active TB? Latent Active
If latent TB, Yes No Will TB treatment be started before initiation of therapy with ixekizumab (Taltz)?

Psoriatic Arthritis

Yes No Does the patient have **axial** psoriatic arthritis?
 Yes No Is there evidence that the disease is active?
 Yes No Has the patient had an ineffective response to at least **TWO (NSAIDs)**?
Provide the names and date ranges: NSAID #1: _____ Date range: ____ / ____ / ____ to ____ / ____ / ____
NSAID #2: _____ Date range: ____ / ____ / ____ to ____ / ____ / ____

Yes No Does the patient have **non-axial** psoriatic arthritis?
 Yes No Is there evidence that the disease is active?
 Yes No Was the treatment with methotrexate ineffective? **If yes**, Date range: ____ / ____ / ____ to ____ / ____ / ____
 Yes No Was the treatment with methotrexate not tolerated or contraindicated?
 Not tolerated Contraindicated
 Yes No Has the patient had an ineffective response to at least 1 (other than methotrexate) conventional (DMARD)?
Provide the name and date range: Name: _____ Date range: ____ / ____ / ____

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB
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G. CLINICAL INFORMATION (continued) – Required clinical information must be completed in its entirety for all precertification requests.

Plaque Psoriasis:

Yes No Is there clinical documentation of chronic disease?
 ↳ Please indicate the severity of the patient's plaque psoriasis: Mild Moderate Severe

Yes No Is there evidence that the disease is active?

Yes No Is the patient a candidate for systemic therapy or phototherapy? phototherapy systemic both

Please provide the patient's Psoriasis Area and Severity Index (PASI) score: _____

Please indicate the percentage of body surface area affected by plaque psoriasis: _____%

Yes No Does the plaque psoriasis affect sensitive areas? Check all that apply: Hands Feet Face Genitals

Yes No Was the trial with systemic conventional DMARD(s) (e.g., methotrexate, acetretin, or cyclosporine) ineffective?
 Provide the name and date range: Name: _____ Date range: ____/____/____ to ____/____/____

Yes No Was the trial with systemic conventional DMARD(s) not tolerated?

Yes No Is systemic conventional DMARD(s) contraindicated?

Yes No Was the trial with phototherapy ineffective? Please check all that apply:
 Psoralens (methoxsalen, trioxsalen) with UVA light (PUVA) Home UVB
 UVB (standard or narrow-band) UVB with coal tar or dithranol
 Date range of phototherapy use: ____/____/____ to ____/____/____

Yes No Was the trial with phototherapy not tolerated?

Yes No Is phototherapy contraindicated?

Yes No Is systemic therapy **and** phototherapy contraindicated?

For Continuation of Therapy Requests: (Clinical documentation required for all requests)

Yes No Will ixekizumab (Taltz) be given concomitantly with apremilast, tofacitinib, or other biologic DMARDs (e.g., adalimumab, infliximab)?

Yes No Has the patient received samples of ixekizumab (Taltz)? (Sampling of Taltz does not guarantee coverage under the provisions of the pharmacy benefit)

Please indicate the length of time on ixekizumab (Taltz): _____

Yes No Is there clinical documentation of disease stability or improvement? Disease stability Improvement

Yes No Does the patient have any risk factors for TB?
 ↳ Yes No Has the patient had a TB test within the past 12 months?
 (check all that apply): PPD test interferon-gamma assay (IGRA) chest x-ray
 Please enter the date and results of the TB test: Date: ____/____/____
 Results: Positive Negative Unknown

H. ACKNOWLEDGEMENT

Request Completed By (Signature Required): _____ **Date:** ____/____/____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The plan may request additional information or clarification, if needed, to evaluate requests.