

**NC Medicaid
Pharmacy Prior Approval Request
Immunomodulators: Taltz**

Beneficiary Information

1. Beneficiary Last Name: _____ 2. First Name: _____
3. Beneficiary ID #: _____ 4. Beneficiary Date of Birth: _____ 5. Beneficiary Gender: _____

Prescriber Information

6. Prescribing Provider NPI #: _____
7. Requester Contact Information - Name: _____ Phone #: _____ Ext. _____

Drug Information

8. Drug Name: _____ 9. Strength: _____ 10. Quantity Per 30 Days: _____
11. Length of Therapy (in days): up to 30 Days 60 Days 90 Days 120 Days 180 Days 365
Days Other _____

Clinical Information

Requests for Ankylosing Spondylitis:

1. Does the beneficiary have a diagnosis of Ankylosing Spondylitis? Yes No
2. Is the beneficiary not on another injectable biologic immunomodulator? Yes No
3. Has the beneficiary been considered and screened for the presence of latent tuberculosis infection? Yes No
4. Has the beneficiary been tested with Hep B SAG and Core Ab? Yes No
5. Has the beneficiary experienced inadequate symptom relief from treatment with at least two NSAIDs? Yes No
6. Is the beneficiary unable to receive treatment with NSAIDs due to contraindications? Yes No
7. Does the beneficiary have clinical evidence of severe or rapidly progressing disease? Yes No
8. Has the beneficiary had a trial and failure of Cosentyx, Enbrel or Humira or have a clinical reason they cannot try Cosentyx, Enbrel or Humira? Yes No

Requests for Plaque psoriasis (Pediatric):

1. Does the beneficiary have a diagnosis of plaque psoriasis and is a candidate for systemic therapy or phototherapy? Yes No
2. Is the beneficiary not on another injectable biologic immunomodulator? Yes No
3. Has the beneficiary been considered and screened for the presence of latent tuberculosis infection? Yes No
4. Has the beneficiary been tested with Hep B SAG and Core Ab? Yes No
5. Has the beneficiary experienced a therapeutic failure/inadequate response with or has a contraindication or intolerance to methotrexate? Yes No
6. Does the beneficiary have body surface area (BSA) involvement of at least 3%? Yes No
7. Does the beneficiary have involvement of the palms, soles, head and neck, or genitalia, causing disruption in normal daily activities and/or employment? Yes No
8. For ages 6 and up has there been a trial and failure of Cosentyx, Enbrel or Humira or have a clinical reason they cannot try Cosentyx, Enbrel or Humira? Yes No

**NC Medicaid
Pharmacy Prior Approval Request**

Requests for Plaque psoriasis (Adult):

1. Does the beneficiary have a documented definitive diagnosis of moderate-to-severe Chronic Plaque Psoriasis? **Yes** **No**
2. Is the beneficiary 18 years of age or older? **Yes** **No**
3. Is the beneficiary not on another injectable biologic immunomodulator? **Yes** **No**
4. Has the beneficiary been considered and screened for the presence of latent tuberculosis infection? **Yes** **No**
5. Has the beneficiary been tested with Hep B SAG and Core Ab? **Yes** **No**
6. Does the beneficiary have body surface area (BSA) involvement of at least 3%? **Yes** **No**
7. Does the beneficiary have involvement of the palms, soles, head and neck, or genitalia, causing disruption in normal daily activities and/or employment?
8. Has the beneficiary failed to respond to, or has been unable to tolerate phototherapy and **ONE** of the following medications or beneficiary has contraindications to these treatments: Soriatane (acitretin), Methotrexate, and/or Cyclosporine? **Yes** **No**
9. Has the beneficiary had a trial and failure of Cosentyx, Enbrel or Humira or have a clinical reason they cannot try Cosentyx, Enbrel or Humira? **Yes** **No**

Requests for Psoriatic Arthritis:

1. Does the beneficiary have a documented definitive diagnosis of Psoriatic Arthritis? **Yes** **No**
2. Is the beneficiary 18 years of age or older? **Yes** **No**
3. Is the beneficiary not on another injectable biologic immunomodulator? **Yes** **No**
4. Has the beneficiary been considered and screened for the presence of latent tuberculosis infection? **Yes** **No**
5. Has the beneficiary been tested with Hep B SAG and Core Ab? **Yes** **No**
6. Does the beneficiary have a documented inadequate response or inability to take methotrexate? **Yes** **No**
7. Has the beneficiary had a trial and failure of Cosentyx, Enbrel or Humira or have a clinical reason they cannot try Cosentyx, Enbrel or Humira? **Yes** **No**

Requests for Non-Radiographic Axial Spondylorthritis:

1. Does the beneficiary have a diagnosis of Non-Radiographic Axial Spondyloarthritis? **Yes** **No**
2. Is the beneficiary not on another injectable biologic immunomodulator? **Yes** **No**
3. Has the beneficiary failed an adequate trial of a Non-Steroidal Anti-Inflammatory Drug (NSAID) unless contraindicated? **Yes** **No**
4. Has the beneficiary been considered and screened for the presence of latent tuberculosis infection? **Yes** **No**
5. Has the beneficiary been tested with Hep B SAG and Core Ab? **Yes** **No**
6. Has the beneficiary had a trial and failure of Cosentyx or a clinical reason beneficiary cannot try Cosentyx? **Yes** **No**

Signature of Prescriber: _____ Date: _____

(Prescriber Signature Mandatory)

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.