

# TEXAS MEDICAID Clinical Edit Prior Authorization ixekizumab (TALTZ)

## STEP 1: CLEARLY PRINT AND COMPLETE TO EXPEDITE PROCESSING

Date:	Prescriber First & Last Name:
Patient First & Last Name:	Prescriber NPI:
Patient Address:	Prescriber Address:
Patient ID:	Prescriber Phone:
Patient Date of Birth:	Prescriber Fax:

## STEP 2: MEDICATION INFORMATION

Medication Requested (Name):	Quantity Requested:
Dose Requested:	Dosing Instructions:

Patient's Primary Diagnosis: \_\_\_\_\_ ICD 10 Code: \_\_\_\_\_

Please indicate ONE (1) of the following:

STAR / STAR KIDS client (**Go to Step 3 - PDL PA Criteria Applies**)

**OR**  CHIP / PERINATE client (**Go to Step 4**)

## STEP 3: PDL PRIOR AUTHORIZATION CRITERIA FOR NON-PREFERRED PRODUCT

1. Has the client failed a 30-day treatment trial with at least one (1) preferred agent in the last 180 days?

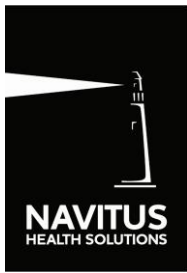
Yes (Go to Step 4 Question 1)  No (Go to #2)

2. Is there a documented allergy or contraindication to preferred agents in this class?

Yes (Go to Step 4 Question 1)  No (Go to #3)

3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?

Yes (Go to Step 4 Question 1)  No (Deny)



**STEP 4: CLINICAL PRIOR AUTHORIZATION CRITERIA**

1. Is the client greater than or equal to ( $\geq$ ) 6 years of age?

Yes (Go to #2)

No (Deny)

2. Does the client have a diagnosis of moderate to severe Plaque Psoriasis (Ps) in the last 730 days?

Yes (Go to #5)

No (Go to #3)

3. Is the client greater than or equal to ( $\geq$ ) 18 years of age?

Yes (Go to #4)

No (Deny)

4. Does the client have a diagnosis of Psoriatic Arthritis (PsA), Ankylosing Spondylitis (AS) or Non-Radiographic Axial Spondyloarthritis (nr-axSpA) in the last 730 days?

Yes (Go to #5)

No (Deny)

5. Does the client have one (1) claim for another biologic drug in the last 30 days?

Examples of biologic drugs include CIMZIA, COSENTYX, ENBREL, HUMIRA, REMICADE, SILIQ, STELARA, and TREMFYA.

Yes (Deny)

No (Go to #6)

6. Does the client have a diagnosis of Crohn's Disease (CD) or Ulcerative Colitis (UC) in the last 365 days?

Yes (Deny)

No (Go to #7)

7. Does the client have a serious active infection (including Hepatitis B virus and/or tuberculosis) in the last 180 days?

Yes (Deny)

No (Approve – 365 days)

**STEP 5: SIGN AND FAX TO: NAVITUS PRIOR AUTHORIZATION AT: 855-668-8553**

**Prescriber Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

If criteria not met, submit chart documentation with form citing complex medical circumstances.  
For questions, please call Navitus Customer Care at 1-877-908-6023.