

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

Member Information <small>(required)</small>			Provider Information <small>(required)</small>		
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 <small>(required)</small>					
Medication Name:			Strength:		Dosage Form:
<input type="checkbox"/> Check if requesting <b>brand</b>			Directions for Use:		
<input type="checkbox"/> Check if request is for <b>continuation of therapy</b>					
Clinical Information <small>(required)</small>					
<b>Select the diagnosis below:</b> <input type="checkbox"/> Moderate to severe plaque psoriasis <input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____					
<b>Clinical Information:</b> Is Taltz prescribed by or in consultation with a dermatologist? <input type="checkbox"/> Yes <input type="checkbox"/> No Select if the patient has history of failure, contraindication, or intolerance to the following: <input type="checkbox"/> Humira (adalimumab) <input type="checkbox"/> Stelara (ustekinumab) Is this request for continuation of prior Taltz therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No Is the patient receiving Taltz in combination with a biologic DMARD [e.g., Enbrel (etanercept), Humira (adalimumab), Cimzia (certolizumab), Simponi (golimumab)]? <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Reauthorization:</b> Is this request for continuation of prior Taltz therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No Is the patient receiving Taltz in combination with a biologic DMARD [e.g., Enbrel (etanercept), Humira (adalimumab), Cimzia (certolizumab), Simponi (golimumab)]? <input type="checkbox"/> Yes <input type="checkbox"/> No					



1230 US Highway 11  
Gouverneur, NY 13642  
Phone: 1-877-635-9545

Prior Authorization Fax: 1-844-712-8129

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

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

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

**Please fax this form to 1-844-712-8129 to initiate a prior authorization review for the member and medication above.**

**Please note: plan benefits may limit or exclude coverage of specific medications including those requested on this form.**

I certify, to the best of my knowledge, the statements and information provided on this form are factual and correct.

Provider/Representative (and Title): \_\_\_\_\_ Date: \_\_\_\_\_

<b>PROACT INTERNAL USE ONLY:</b>				
<b>Clinical Review Decision</b>				
<b>Approved, through</b>				
<b>Denied (documentation attached, if necessary)</b>				
<b>Tracking:</b>				
1 <sup>st</sup> Attempt		2 <sup>nd</sup> Attempt		Letter Mailed:

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