OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.
Visit go.covermymeds.com/OptumRx to begin using this free service.
Please note: All information below is required to process this request.
Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Taltz® Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)

Member Name:		
Insurance ID#:		
Date of Birth:		
Street Address:		
City:	State:	Zip:
Phone:		

Provider Information (required)

Provider Name:		
NPI#:	Specialty:	
Office Phone:		
Office Fax:		
Office Street Address:		
City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

❑ Active psoriatic arthritis
❑ Moderate to severe plaque psoriasis
❑ 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**

For active psoriatic arthritis, also answer the following:

Select if the patient has had a trial and failure, contraindication, or intolerance to the following:
❑ Cimzia (certolizumab pegol) ❑ Humira (adalimumab) ❑ Tremfya (guselkumab)
❑ Cosentyx (secukinumab) ❑ Stelara (ustekinumab) ❑ Xeljanz (tofacitinib) or Xeljanz XR (tofacitinib ER)
❑ Other: _____

For moderate to severe plaque psoriasis, also answer the following:

Select if the patient has had a trial and failure, contraindication, or intolerance to the following:
❑ Cimzia (certolizumab pegol) ❑ Humira (adalimumab) ❑ Tremfya (guselkumab)
❑ Cosentyx (secukinumab) ❑ Stelara (ustekinumab) ❑ Other: _____

Reauthorization:

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**

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.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.