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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)			Provider Information (required)		
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 (required)			
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 (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?**

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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.

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