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)			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:
❑ 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
❑ Chronic moderate to severe plaque psoriasis
❑ Other diagnosis: ____________________________________ ICD-10 Code(s): ________________________________

Clinical Information:

For chronic moderate to severe plaque psoriasis, select if the following applies to the patient:
- ❑ Greater than or equal to 5% body surface area involvement
- ❑ Palmoplantar (i.e., palms, soles), facial, or genital involvement
- ❑ Severe scalp psoriasis

Select if Taltz is prescribed by or in consultation with one of the following specialists:
- ❑ Dermatologist
- ❑ Rheumatologist

Select if the patient has trial and failure, contraindication, or intolerance to the following, if appropriate for the patient's diagnosis:
- ❑ Cosentyx (secukinumab)
- ❑ Enbrel (etanercept)
- ❑ Humira (adalimumab)
- ❑ Stelara (ustekinumab)
- ❑ Tremfya (guselkumab)

Is this request for continuation of prior Taltz therapy? ❑ **Yes** ❑ **No**

Will the patient be receiving Taltz in combination with a biologic DMARD [e.g., Enbrel (etanercept), Humira (adalimumab), Cimzia (certolizumab), Simponi (golimumab)]? ❑ **Yes** ❑ **No**

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.
If the patient is not able to meet the above standard prior authorization requirements, please call 1-800-711-4555.
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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