

CRITERIA FOR PRIOR AUTHORIZATION

Taltz® (ixekizumab)

PROVIDER GROUP Pharmacy
Professional

MANUAL GUIDELINES The following drug requires prior authorization:
Ixekizumab (Taltz)

CRITERIA FOR MODERATE TO SEVERE PLAQUE PSORIASIS: (must meet all of the following)

- Patient must have a diagnosis of moderate to severe plaque psoriasis
- Patient must be 18 years or older
- Patient must be a candidate for systemic therapy or phototherapy
- Must be prescribed by or in consultation with a Dermatologist or Rheumatologist
- Evaluation for latent tuberculosis infection with TB skin test prior to initial PA
- Patient has not taken another biologic agent in the past 30 days
- Patient must not have concurrent Crohn’s disease or Ulcerative colitis

LENGTH OF APPROVAL: 12 MONTHS

Notes:

- Recommended dose is 160 mg (two 80 mg injections) at week 0, followed by 80 mg at weeks 2, 4, 6, 8, 10, and 12, then 80 mg every 4 weeks.

DRUG UTILIZATION REVIEW COMMITTEE CHAIR

PHARMACY PROGRAM MANAGER
DIVISION OF HEALTH CARE FINANCE
KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT

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Biologic Agents	
Generic Name	Brand Name
Abatacept	Orencia®
Adalimumab	Humira®
Alefacept	Amevive®
Anakinra	Kineret®
Certolizumab	Cimzia®
Golimumab	Simponi®
Infliximab	Remicade®
Natalizumab	Tysabri®
Rituximab	Rituxan®
Tocilizumab	Actemra®
Ustekinumab	Stelara®
Tofacitinib	Xeljanz®, Xeljanz XR
Etanercept	Enbrel®
Canakinumab	Ilaris
Apremilast	Otezla
Secukinumab	Cosentyx
Vedolizumab	Entyvio