Sample Coverage Authorization Request Letter

HCPs can follow this format for patients who are **NOT** currently receiving treatment with Taltz® (ixekizumab) 80 mg/mL.

<Date>
<Prior authorization department>
<Name of health plan>
<Mailing address>

Re: **<Patient's name>**
<Plan identification number>
<Date>

To whom it may concern:

This letter serves as a coverage authorization request for Taltz (ixekizumab) for **<patient's name, plan identification number, and group number>** for the treatment of **<diagnosis and ICD code>** .

Patient's history, diagnosis, condition, and symptoms*:

Please detail all past treatments:

Past treatment(s)†	Start/stop dates	Reason(s) for discontinuing

<Please provide information that indicates the patient does not have active tuberculosis or other serious infections (required by some health plans). If the patient does have serious infections, please include that information as follows:

Infection name and affected part(s) of body	Treatment type(s)	Treatment start/stop dates	Anticipated resolution date>

<Please affirm that the patient will not be taking Taltz in combination with another biologic therapy.>

<Insert rationale for prescribing Taltz here, including your professional opinion of the patient's likely prognosis or disease progression without Taltz treatment.>

<Please provide the clinical rationale for why your patient would benefit from using this agent prior to the payer-preferred agent when managing his/her condition.>

Provide supporting references for your recommendation:

<Provide clinical rationale for treatment; this information may be found in the Taltz Prescribing Information and/or clinical peer-reviewed literature.>

Physician contact information:
The ordering physician is **<physician name, NPI #>** . The coverage authorization decision may be faxed to **<fax #>** or mailed to **<physician office mailing address>** . Please send a copy of the coverage determination decision to **<patient's name, street address, city, state, ZIP>** .

Sincerely,

<Physician's name and signature>
<Physician's contact information>

<Patient's name and signature>

Encl: Medical records, supporting documentation, photo(s), and clinical trial information

*Include patient's medical records and supporting documentation, including clinical evaluation, scoring forms, and photos of affected areas as applicable.
†Identify drug name, strength, dosage form, and therapeutic outcome.
ICD, International Classification of Diseases.