PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Stelara (Ustekinumab)

Phone: 800-728-7947 Fax back to: 866-880-4532

The Scott & White Health Plan Pharmacy Department manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:	**Prescriber Name:** **Supervising Physician:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. Select the regimen being requested.

- ☐ Stelara 90 mg SQ every 12 weeks
- ☐ Stelara 45 mg SQ every 12 weeks
- ☐ IV Induction: 260 mg, 390 mg, or 520 mg (Please specify and provide current weight)
- ☐ Other

Q2. What diagnosis is this drug being prescribed for (select ALL that apply)?

☐ Plaque psoriasis ☐ Psoriatic arthritis ☐ Crohn's Disease ☐ Other

Q3. Provide ICD code(s) for diagnosis.

Q4. What is the prescriber's specialty?

☐ Dermatologist ☐ Rheumatologist ☐ Gastroenterology ☐ Other

Q5. Select ALL of the following that apply to the patient:

- ☐ Moderate to severe PLAQUE PSORIASIS affecting GREATER THAN 5% of body surface area (BSA)
- ☐ Moderate to severe PLAQUE PSORIASIS affecting CRUCIAL BODY AREAS such as hands, feet, face, or genitals
- ☐ PSORIATIC ARTHRITIS with documented SPINAL INVOLVEMENT (psoriatic spondylitis)

PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Stelara (Ustekinumab)

Phone: 800-728-7947 Fax back to: 866-880-4532

The Scott & White Health Plan Pharmacy Department manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:	**Prescriber Name:** **Supervising Physician:**

☐ None of the above

Q6. Has the patient failed at least TWO TOPICAL treatments [including but not limited to corticosteroids, Vitamin D analogues, Vitamin D analogue/corticosteroid combinations, Tazorac® (tazarotene)]?

☐ Yes
☐ No
☐ N/A - Patient does not have plaque psoriasis

Q7. Has the patient failed, or does the patient have a contraindication to phototherapy (UVB or PUVA)?

☐ Yes
☐ No
☐ N/A - Patient does not have plaque psoriasis

Q8. Select ALL of the following that apply to this patient:

☐ For psoriasis, failed AT LEAST ONE of the following: methotrexate, cyclosporine, acitretin, leflunomide, sulfasalazine, tacrolimus
☐ For psoriasis, contraindication to methotrexate, cyclosporine, acitretin, leflunomide, sulfasalazine, or tacrolimus
☐ For psoriatic arthritis, failed methotrexate
☐ For psoriatic arthritis, contraindication to methotrexate
☐ For psoriastic arthritis, failed AT LEAST ONE of the following: hydroxychloroquine, sulfasalazine, leflunomide, azathioprine, D-penicillamine, gold (oral or IM), minocycline, cyclosporine, staphylococcal protein A immunoadsorption
☐ For psoriatic arthritis, contraindication to hydroxychloroquine, sulfasalazine, leflunomide, azathioprine, D-penicillamine, gold (oral or IM), minocycline, cyclosporine, AND staphylococcal protein A immunoadsorption
☐ For Crohn's Disease, failure of or contraindication to an anti-inflammatory drug (e.g. mesalamine, sulfasalazine), corticosteroid, or an immunosuppressive

Q9. Is the patient a NEW START to Stelara?

☐ Yes ☐ No

Q10. Select the agents the patient has failed

☐ Enbrel
☐ Humira
☐ Other (please specify)
☐ None

Q11. Has the patient failed Cosentyx?

PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Stelara (Ustekinumab)

Phone: 800-728-7947 Fax back to: 866-880-4532

The Scott & White Health Plan Pharmacy Department manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:	**Prescriber Name:** **Supervising Physician:**

☐ Yes ☐ No

Q12. What is the patient's weight?

- ☐ Less than or equal to 55 kg (121 lbs)
- ☐ 55 to 85 kg (121 to 187 lbs)
- ☐ 86 to 100 kg (189 to 220 lbs)
- ☐ Less than or equal to 100 kg (220 lbs)
- ☐ Greater than 100 kg (220 lbs)

Q13. Additional Comments

Prescriber Signature

Date

□ Expedited/Urgent - By checking this box and signing above, I certify that applying the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function

Lack of the necessary documentation may result in a medical necessity denial. Requesting providers may speak to the SWHP medical director at 1-888-316-7947 regarding the case to have an opportunity to help impact the decision on a request before coverage has been decided.