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 SubQ every 8 weeks
- ☐ Stelara 90 mg SubQ every 12 weeks
- ☐ Stelara 45 mg SubQ every 12 weeks
- ☐ IV Induction: 260 mg
- ☐ IV Induction: 390 mg
- ☐ IV Induction: 520 mg
- ☐ 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?

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☐ Dermatologist
☐ Rheumatologist
☐ Gastroenterology
☐ Other

Q5. Is the patient a NEW START to Stelara?

☐ Yes ☐ No

Q6. 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)
☐ None of the above

Q7. Has the patient failed an adequate trial of 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

Q8. Has the patient failed an adequate trial of, or does the patient have a contraindication to phototherapy (UVB or PUVA)?

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

Q9. 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, intolerance or contraindication to methotrexate, cyclosporine, acitretin, leflunomide, sulfasalazine, AND tacrolimus
☐ For psoriatic arthritis, failed methotrexate
☐ For psoriatic arthritis, contraindication to methotrexate
☐ For psoriatic arthritis, failed AT LEAST ONE of the following: hydroxychloroquine, sulfasalazine, leflunomide
☐ For psoriatic arthritis, contraindication to hydroxychloroquine, sulfasalazine, leflunomide

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☐ For Crohn's Disease, failure of an adequate trial of, clinically significant intolerance, or contraindication(s) to an anti-inflammatory drug (e.g. mesalamine, sulfasalazine), corticosteroid, or an immunosuppressive

Q10. Does the patient have failure of an adequate trial of, clinically significant intolerance, or contraindication to any of the following?

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

Q11. Does the patient have failure of an adequate trial of, clinically significant intolerance, or contraindication to Cosentyx?

☐ 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)
- ☐ Greater than 100 kg (220 lbs)

Q13. For continuation of Stelara for Crohn's disease, is there documentation of clinical response from the IV initiation dose? [Please submit clinical documentation]

☐ Yes ☐ No

Q14. How will drug be billed?

- ☐ Pharmacy claim (drug to be billed as a PHARMACY benefit claim and dispensed by pharmacy directly to member)
- ☐ Pharmacy claim (drug to be billed as a PHARMACY benefit claim, but shipped direct to provider to be administered to this specific member)
- ☐ MEDICAL claim (drug to be billed by PROVIDER as a MEDICAL benefit claim as an expense to the provider, and provider to supply drug to member)

Q15. If billing as a MEDICAL claim, what provider will be linked to the claim (i.e. who is the billing entity seeking reimbursement)? Provide Name and NPI

- ☐ Individual prescriber
- ☐ Provider or specialty group
- ☐ Facility

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Q16. 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 a SWHP pharmacist or medical director at 1-800-728-7947 regarding the case to have an opportunity to help impact the decision on a request before coverage has been decided.