# PRIOR AUTHORIZATION REQUEST
## *Stelara*

PATIENT: Name______________________
Address: ______________________
City, State, Zip_____________________
D.O.B. _____________________
Member ID:________________________

Prescriber: Name______________________
Address ______________________
City, State, Zip_____________________
Phone _____________________
Fax _____________________
NPI _____________________

**Medication Requested:___________ Qty Requested: ___________**

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

## SECTION A: Please answer the following questions

1. Is the medication to be used in combination with a BIOLOGIC OR a Targeted Synthetic DMARD?
   - ☐ Biologics
   - ☐ Targeted synthetic DMARD
   - ☐ Conventional synthetic DMARD
   - ☐ No, The requested medication will NOT be used in combination with another BIOLOGIC or Targeted Synthetic disease-modifying antirheumatic drug (DMARD)
2. ☐ Yes ☐ No Is the patient currently receiving Stelara SC?
3. What is the indication or diagnosis?
   - ☐ Crohn's disease – **Please answer questions 9 – 13, 16**
   - ☐ Plaque psoriasis – **Please answer questions 4 – 7, 14**
   - ☐ Ulcerative colitis – **Please answer questions 9, 10, 17, 18**
   - ☐ Psoriatic arthritis (PsA) – **Please answer questions 8, 15**
   - ☐ Ankylosing spondylitis (AS)
   - ☐ All other indications (Please specify) ____________________________________________
4. ☐ Yes ☐ No Is the requested medication being prescribed by, or in consultation with, a dermatologist?
5. ☐ Yes ☐ No Has the patient tried at least one traditional systemic agent for psoriasis for at least 3 months, unless intolerant?
6. ☐ Yes ☐ No Has the patient already had a 3-month trial or previous intolerance to at least one biologic?
7. ☐ Yes ☐ No Does the patient have a contraindication to methotrexate, as determined by the prescriber?
8. ☐ Yes ☐ No Is the requested medication being prescribed by or in consultation with a rheumatologist or a dermatologist?
9. ☐ Yes ☐ No Is the requested medication prescribed by or in consultation with a

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gastroenterologist?

10. ☐ Yes ☐ No According to the prescriber, will the patient receive a single induction dose with Stelara IV within 2 months of initiating therapy with Stelara SC?
11. ☐ Yes ☐ No Has the patient tried corticosteroids, or the patient is currently on corticosteroids, or are corticosteroids contraindicated in this patient?
12. ☐ Yes ☐ No Has the patient tried one conventional systemic therapy for Crohn's disease?
13. ☐ Yes ☐ No Has the patient tried a biologic?
14. ☐ Yes ☐ No Has the patient responded to the requested medication, as determined by the prescriber?
15. ☐ Yes ☐ No Has the patient responded to Stelara SC as determined by the prescriber?
16. ☐ Yes ☐ No Has the patient had a response as determined by the prescriber?
17. ☐ Yes ☐ No Has the patient had a response as determined by the prescriber?
18. ☐ Yes ☐ No Has the patient had a trial of one systemic agent for ulcerative colitis?

***Please document the diagnoses, symptoms, and/or any other information important to this review:***

____________________________________________________________

____________________________________________________________

## SECTION B Physician Signature

____________________________________________________________

PHYSICIAN SIGNATURE DATE

## FAX COMPLETED FORM TO: 877-251-5896

**Disclaimer:** An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior

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