PRIOR AUTHORIZATION REQUEST

USTEKINUMAB PRODUCTS

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

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 note that supporting clinical documentation is required for **ALL** PA requests. Pharmacy prior authorization reviews can be subject to trial with additional medications that are not listed within the criteria. The policies are subject to change based on COMAR requirements, MDH transmittals and updates to treatment guidelines.

1	Is this request for initial therapy or for a continuation of therapy? [] Initial (If checked, go to 8) [] Continuation (If checked, go to 2)		
2	Will the requested medication be used in combination with a biologic disease-modifying antirheumatic drug (DMARD) or targeted synthetic DMARD? [Note: Examples of biologics include but not limited to adalimumab SC products	Yes	No

If you have any questions, call: 1-888-258-8250

PRIOR AUTHORIZATION REQUEST

	(Humira, biosimilars), Cimzia, etanercept SC products (Enbrel, biosimilars), infliximab IV products (Remicade, biosimilars), Actemra (IV or SC), Simponi, Simponi Aria (IV or SC), Orencia (IV or SC), rituximab IV products (Rituxan, biosimilars), Kineret, Siliq, Cosentyx, Taltz, Ilumya, Skyrizi, Tremfya, Entyvio. Examples of targeted synthetic DMARD include but not limited to Otezla, Olumiant, Rinvoq, or Xeljanz/XR.] [If yes, no further questions.]		
3	Is the patient currently receiving the requested medication? [If no, skip to question 8.]	Yes	No
4	Has the patient been receiving medication samples of the requested medication? [If yes, skip to question 8.]	Yes	No
5	Does the patient have a previously approved prior authorization (PA) on file with the current plan? [Note: If the patient does NOT have a previously approved PA on file for the requested medication with the current plan, the renewal request will be considered under initial therapy.] [If no, skip to question 8.]	Yes	No
6	Has the patient been established on therapy for at least 3 months? [If no, skip to question 8.]	Yes	No
7	Has documentation been submitted to confirm that the patient has had a significant response to therapy, as determined by the provider? ACTION REQUIRED: Submit supporting documentation. [No further questions.]	Yes	No
8	Will the requested medication be used in combination with a biologic disease-modifying antirheumatic drug (DMARD) or targeted synthetic DMARD? [Note: Examples of biologics include but not limited to adalimumab SC products (Humira, biosimilars), Cimzia, etanercept SC products (Enbrel, biosimilars), infliximab IV products (Remicade, biosimilars), Actemra (IV or SC), Simponi, Simponi Aria (IV or SC), Orencia (IV or SC), rituximab IV products (Rituxan, biosimilars), Kineret, Siliq, Cosentyx, Taltz, Ilumya, Skyrizi, Tremfya, Entyvio. Examples of targeted synthetic DMARD include but not limited to Otezla, Olumiant, Rinvoq, or Xeljanz/XR.] [If yes, no further questions.]	Yes	No
9	What is the requested medication formulation? [] INTRAVENOUS (If checked, go to 23) [] SUBCUTANEOUS (If checked, go to 10)		
10	Is the request for a formulary Ustekinumab product (Pyzchiva, Steqeyma, or Yesintek)?	Yes	No

PRIOR AUTHORIZATION REQUEST

	[If yes, skip to question 12.]		
11	Does the patient have documented intolerance or failed treatment for at least 3 months with preferred Ustekinumab product(s) (Pyzchiva, Steqeyma, or Yesintek)? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
12	What is the indication or diagnosis? [] Plaque Psoriasis (If checked, go to 13) [] Psoriatic Arthritis (If checked, go to 18) [] Crohn's Disease [Note: Includes adults with fistulizing Crohn's disease or Crohn's disease of the ileal pouch.] (If checked, no further questions) [] Ulcerative Colitis (If checked, no further questions) [] Ankylosing Spondylitis (If checked, no further questions) [] Other (If checked, no further questions)		
13	Is the patient greater than or equal to 6 years of age? [If no, no further questions.]	Yes	No
14	Has documentation been provided to confirm that the patient has tried at least TWO traditional systemic agents for psoriasis for at least 3 months or has a documented intolerance or contraindication to at least TWO traditional systemic agents for psoriasis? ACTION REQUIRED: Submit supporting documentation. [Note: Examples of traditional systemic agents include methotrexate, cyclosporine, or acitretin.] [If no, no further questions.]	Yes	No
15	Has documentation been submitted to confirm that the patient has an intolerance, contraindication to, or failed treatment for at least 3 months with preferred TNF inhibitor, an adalimumab product (Hadlima, Simlandi, Yusimry, or adalimumab-adbm)? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
16	Is the requested medication being prescribed by, or in consultation with, a dermatologist? [If no, no further questions.]	Yes	No
17	Does the dose of the requested medication exceed the Food and Drug Administration (FDA) approved label dosing for the indication? (Dosing weight less than 60 kg: 0.75 mg/kg at weeks 0, 4 and then every 12 weeks thereafter. Dosing weight 60 kg to 100 kg: 45 mg at weeks 0, 4 and then every 12 weeks thereafter. Dosing weight greater than 100 kg: 90 mg at weeks 0, 4 and then every 12 weeks	Yes	No

PRIOR AUTHORIZATION REQUEST

	thereafter.) [No further questions.]		
18	Is the patient greater than or equal to 6 years of age? [If no, no further questions.]	Yes	No
19	Has the patient tried TWO conventional synthetic disease-modifying antirheumatic drugs (DMARDs) for at least 3 months such as methotrexate (oral or injectable), leflunomide, hydroxychloroquine and/or sulfasalazine? [If no, no further questions.]	Yes	No
20	Has documentation been submitted to confirm that the patient has an intolerance, contraindication to, or failed treatment for at least 3 months with preferred TNF inhibitor, an adalimumab product (Hadlima, Simlandi, Yusimry, or adalimumab-adbm)? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
21	Is the requested medication being prescribed by, or in consultation with, a dermatologist or rheumatologist? [If no, no further questions.]	Yes	No
22	Does the dose of the requested medication exceed the Food and Drug Administration (FDA) approved label dosing for the indication? (Dosing weight less than 60 kg: 0.75 mg/kg at weeks 0, 4 and then every 12 weeks thereafter. Dosing weight 60 kg to 100 kg: 45 mg at weeks 0, 4 and then every 12 weeks thereafter. Dosing weight greater than 100 kg: 90 mg at weeks 0, 4 and then every 12 weeks thereafter.) [No further questions.]	Yes	No
23	Is the request for a formulary Ustekinumab product (Pyzchiva, Steqeyma, or Yesintek)? [If yes, skip to question 25.]	Yes	No
24	Does the patient have documented intolerance or failed treatment for a least 3 months with preferred Ustekinumab product(s) (Pyzchiva, Steqeyma, or Yesintek)? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
25	Will the requested medication be used as induction therapy? [If no, no further questions.]	Yes	No
26	What is the indication or diagnosis? [] Crohn's Disease [Note: Includes adults with fistulizing Crohn's disease or Crohn's disease of the ileal pouch.] (If checked, go to 27) [] Ulcerative Colitis (If checked, go to 32)		

PRIOR AUTHORIZATION REQUEST

	[] Plaque Psoriasis (If checked, no further questions)		
	[] Psoriatic Arthritis (If checked, no further questions)		
	[] Other (If checked, no further questions)		
27	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No
28	Has the patient tried TWO other conventional systemic therapies for Crohn's disease or was intolerant to other conventional systemic therapies? [Note: Examples of other agents for Crohn's disease include azathioprine, 6-mercaptopurine, or methotrexate.] [If no, no further questions.]	Yes	No
29	Has documentation been submitted to confirm that the patient has had an intolerance, contraindication to, or failed treatment for at least 3 months with preferred TNF inhibitor, an adalimumab product (Hadlima, Simlandi, Yusimry, or adalimumab-adbm)? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
30	Is the requested medication being prescribed by, or in consultation with, a gastroenterologist? [If no, no further questions.]	Yes	No
31	Does the dose exceed the Food and Drug Administration (FDA) approved label dosing for the indication? (Dosing weight less than 55 kg: 260 mg. Dosing weight 55 to 85 kg: 390 mg. Dosing weight greater than 85 kg: 520 mg.) [No further questions.]	Yes	No
32	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No
33	Has the patient had a trial of TWO systemic agents for ulcerative colitis or was intolerant to systemic agent? [Note: Examples of systemic agents include 6-mercaptopurine, azathioprine, cyclosporine, tacrolimus, or a corticosteroid such as prednisone or methylprednisolone.] [If no, no further questions.]	Yes	No
34	Has documentation been submitted to confirm that the patient has had an intolerance, contraindication to, or failed treatment for at least 3 months with preferred TNF inhibitor, an adalimumab product (Hadlima, Simlandi, Yusimry, or adalimumab-adbm)? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
35	Is the requested medication being prescribed by, or in consultation with, a gastroenterologist?	Yes	No

PRIOR AUTHORIZATION REQUEST

	[If no, no further questions.]		
36	Does the dose exceed the Food and Drug Administration (FDA) approved label dosing for the indication? (Dosing weight less than 55 kg: 260 mg. Dosing weight 55 to 85 kg: 390 mg. Dosing weight greater than 85 kg: 520 mg.)	Yes	No

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: 1-833-896-0656

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 authorization as per Plan policy and procedures.

Confidentiality: The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.

If you have any questions, call: 1-888-258-8250