Stelara (ustekinumab)
Prior Authorization Request Form

Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

☐ **URGENT**

MEMBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PHONE NUMBER:	**DATE OF BIRTH:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
PATIENT INSURANCE ID NUMBER:	

☐ **MALE** ☐ **FEMALE** **HEIGHT (IN/CM):** _____ **WEIGHT (LB/KG):** _____ **ALLERGIES:** _____

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: PRIMETHERAPEUTICS.COM/NOPP

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): _____

AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: _____

PRESCRIBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PRESCRIBER SPECIALTY:	**EMAIL ADDRESS:**
NPI NUMBER:	**DEA NUMBER:**
PHONE NUMBER:	**FAX NUMBER:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
REQUESTOR (if different than prescriber)**:**	**OFFICE CONTACT PERSON:**

MEDICATION OR MEDICAL DISPENSING INFORMATION			
MEDICATION NAME:			
DOSE/STRENGTH:	**FREQUENCY:**	**LENGTH OF THERAPY/REFILLS:**	**QUANTITY:**
☐ **NEW THERAPY** ☐ **RENEWAL** DURATION OF THERAPY (SPECIFIC DATES):		**IF RENEWAL:** DATE THERAPY INITIATED:	

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MEMBER'S LAST NAME: _____ **MEMBER'S FIRST NAME:** _____

1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? ☐ YES (if yes, complete below) ☐ NO		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE)**:**	**DURATION OF THERAPY** (SPECIFY DATES)**:**	**RESPONSE/REASON FOR FAILURE/ALLERGY:**

2. LIST DIAGNOSES:	**ICD-10:**
□ Crohn's disease □ Moderate to severe psoriatic arthritis □ Plaque psoriasis □ Ulcerative colitis □ Other Diagnosis:_____ICD-10 Code(s):_____	

3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.

"Patients previously started on intravenous Stelara must meet all Plan criteria before subcutaneous Stelara will be approved for benefit coverage."

For <u>all diagnoses,</u> answer the following:
Will Stelara be used concurrently with another biologic or immunomodulatory agent? □ Yes □ No

Has the patient tried and had an inadequate response to a three-month trial with the biosimilar for Humira – adalimumab-aacf?* **□ Yes □ No** ***Please provide supporting documentation, including trial dates.***

Select if Stelara is being prescribed by one of the following specialists:
- **□ Dermatologist**
- **□ Gastroenterologist**
- **□ Rheumatologist**

For <u>Crohn's disease,</u> also answer the following:

Select if the patient has tried and had an inadequate response, intolerance, or contraindication to the following systemic therapies:
- **□ Glucocorticoid therapy**
- **□ Methotrexate**
- **□ Azathioprine**
- **□ 6-mercaptopurine**
- **□ 5-ASA/mesalamine**

Please provide supporting documentation, including which agent(s) have been tried and trial dates: _____
_____

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MEMBER'S LAST NAME: _____ **MEMBER'S FIRST NAME:** _____

Select if the patient has a contraindication to all of the following pre-requisite medications or there is a reason why the patient cannot take the following:

□ **Systemic therapy: Glucocorticoid therapy, Methotrexate, Azathioprine, 6-mercaptopurine, and 5-ASA/ mesalamine**

□ **adalimumab-aacf**

Please provide clinical rationale: _____

For moderate to severe psoriatic arthritis, also answer the following:

Has the patient had at least a 3-month trial and failure with an oral non-biologic disease modifying anti-rheumatic agent (DMARD) (e.g., methotrexate, sulfasalazine (Azulfidine), leflunomide (Arava), cyclosporine? □Yes □ No

If "yes" to the above question, please provide supporting documentation, including which agent(s) have been tried and trial dates: _____

For plaque psoriasis, also answer the following:

Does the patient have plaques covering greater than or equal 10% of their body surface area (BSA)? □ Yes □ No

Does the patient have plaques covering less than 10% of their BSA with involvement of palms, soles, head and neck, or genitalia which causes disruption of normal activities? □ Yes □ No

Has the patient has had an inadequate response to previous treatment with phototherapy? □ Yes □ No

Please provide supporting documentation, including which agent(s) have been tried and trial dates: _____

_____

Select if the patient has tried and had an inadequate response, intolerance, or contraindication to the following systemic therapies:

□ **Acitretin**

□ **Methotrexate**

□ **Cyclosporine**

Please provide supporting documentation, including which agent(s) have been tried and trial dates: _____

_____

For Ulcerative Colitis, also answer the following:

Is the request for maintenance therapy ONLY (NOT INDUCTION THERAPY)? □ Yes □ No

Has patient tried and failed at least one of the following three therapies: corticosteroids, azathioprine and/or 6-mercaptopurine? □ Yes □ No *Please provide supporting documentation, including trial dates.*

_____

Select if Stelara is being prescribed by one of the following specialists:

□ **Dermatologist**

□ **Gastroenterologist**

□ **Rheumatologist**

Is patient continuing to respond to therapy? □ Yes □ No *Please submit documentation.*

Will patient use requested medication in combination with another biologic response modifier or immunomodulatory agent? □ Yes □ No

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received.

ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature or Electronic I.D. Verification: _____ Date: _____

FAX THIS FORM TO: 800-424-7640

MAIL REQUESTS TO: Prime Therapeutics Management Prior Authorization Program
Attn: CP – 4201
P.O. Box 64811
St. Paul, MN 55164-0811