

Otulfi (ustekinumab-aauz)
Prior Authorization Request Form
 Caterpillar Prescription Drug Benefit
 Phone: 877-228-7909 Fax: 800-424-7640

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

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:
REQUESTER (if different than prescriber):	OFFICE CONTACT PERSON:	

MEDICATION OR MEDICAL DISPENSING INFORMATION			
MEDICATION NAME:			
DOSE/STRENGTH:	FREQUENCY:	LENGTH OF THERAPY/REFILLS:	QUANTITY:
<input type="checkbox"/> NEW THERAPY <input type="checkbox"/> RENEWAL IF RENEWAL: DATE THERAPY INITIATED:			
DURATION OF THERAPY (SPECIFIC DATES):			

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1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION?		
<input type="checkbox"/> YES (if yes, complete below) <input type="checkbox"/> NO		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE): 	DURATION OF THERAPY (SPECIFY DATES): 	RESPONSE/REASON FOR FAILURE/ALLERGY:
2. LIST DIAGNOSES:		ICD-10:
<input type="checkbox"/> Crohn's disease <input type="checkbox"/> Moderate to severe psoriatic arthritis <input type="checkbox"/> Plaque psoriasis <input type="checkbox"/> Ulcerative colitis <input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____		
3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.		
Is patient going to be using drug in combination with a clinical trial? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Is the request for maintenance therapy ONLY (NOT INDUCTION THERAPY)? <input type="checkbox"/> Yes <input type="checkbox"/> No		
For <u>all diagnoses</u>, answer the following: Will Otulfi(ustekinumab-aauz) be used concurrently with another biologic or immunomodulatory agent? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Has the patient tried and had an inadequate response to a three-month trial with the biosimilar for Humira – adalimumab-aacf? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>*Please provide supporting documentation, including trial dates.</i>		
Does patient have an absolute contraindication to adalimumab-aacf? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>*Please provide supporting documentation.</i>		
Has patient been previously treated with infliximab and/or vedolizumab(Entyvio)? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>*Please provide supporting documentation, including trial dates.</i>		
Select if Otulfi is being prescribed by one of the following specialists: <input type="checkbox"/> Dermatologist <input type="checkbox"/> Gastroenterologist <input type="checkbox"/> 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: (Please provide supporting documentation, including which agent(s) have been tried and trial dates.)		



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- Glucocorticoid therapy
- Methotrexate
- Azathioprine
- 6-mercaptopurine
- 5-ASA/mesalamine

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 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 documentation.

Has the patient tried and had an inadequate response, intolerance, or contraindication to the following systemic therapies: (Please provide supporting documentation, including which agent(s) have been tried and trial dates.)

- Acitretin
- Methotrexate
- Cyclosporine

For Ulcerative Colitis, also answer the following:

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.*

Renewal Request:

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

- Dermatologist
- Gastroenterologist
- Rheumatologist

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

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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:** _____

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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

Phone: 877-228-7909