pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

STELARA (ustekinumab) [non-preferred] PRIOR AUTHORIZATION FORM

Cytokine and CAM Antagonists and **Quantity Limits/Daily Dose Limits** prior authorization guidelines: http://www.dhs.pa.gov/provider/pharmacyservices/index.htm.

PRIOR AUTHORIZATION REQUEST INFORMATION		PRESCRIBER INFORMATION	
☐New request ☐Renewal request	# of pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		State license #:	
LTC facility contact/phone:		NPI:	MA Provider ID#:
BENEFICIARY INFORMATION		Street address:	
Beneficiary name:		Suite #:	City/state/zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Product requested:	☐Stelara 45 mg/0.5 ml syringe ☐Stelara 90 mg/ml syringe	☐Stelara 130 mg/26 ml (5 mg/5 ml) vial ☐Stelara: _____	
Directions:	Quantity:	Refills:	Beneficiary's weight: _____ lbs/kg
Diagnosis (*submit documentation*):			Diagnosis code (*required*):

Specialty Pharmacy Drug Program: Which specialty pharmacy will be used? ☐Diplomat Specialty ☐Walgreen's Specialty

INITIAL requests – complete questions applicable to beneficiary's diagnosis

1.	***All diagnoses***: Check all that apply to the beneficiary and *submit documentation for each*. ☐vaccinated for hepatitis B ☐screened for hepatitis B (surface antigen & core antibody) ☐has been using Stelara in the past 90 days ☐screened for tuberculosis ☐up-to-date with all age-appropriate immunizations	
2.	***ADULT plaque psoriasis:*** Does at least one of the following apply to the beneficiary? ☐at least 5% of body surface area (BSA) is affected ☐critical areas of the body are involved (face, palms, soles, and/or genitals)	☐Yes ☐No *Submit documentation.*
3.	***ADULT plaque psoriasis:*** Does the beneficiary have a history of trial and failure, contraindication, or intolerance of a 3-month trial of phototherapy? *Check all that apply.* ☐PUVA ☐UVB light ☐other: _____	☐Yes ☐No *Submit documentation of all treatments tried and outcomes.*
4.	***ADULT plaque psoriasis:*** Does the beneficiary have a history of trial and failure, contraindication, or intolerance of all of the following medications? *Check all that apply.* ☐acitretin ☐cyclosporine ☐methotrexate	☐Yes ☐No *Submit documentation of all medications tried and outcomes.*
5.	***Plaque psoriasis*:** Does the beneficiary have a history of trial and failure, contraindication, or intolerance of the preferred agents? *Check all that apply.* ☐Cosentyx ☐Humira	☐Yes ☐No *Submit documentation of all medications tried and outcomes.*
6.	***Psoriatic arthritis***: Does the beneficiary have a history of trial and failure, contraindication, or intolerance of the following? ☐four-week trial each of at least 2 different NSAIDs ☐eight-week trial of methotrexate or other DMARD *(does not apply to axial disease)*	☐Yes ☐No *Submit documentation of all medications tried and outcomes.*
7.	***Psoriatic arthritis*:** Does the beneficiary have a history of trial and failure, contraindication, or intolerance of the preferred agents? *Check all that apply.* ☐Cosentyx ☐Humira ☐Xeljanz	☐Yes ☐No *Submit documentation of all medications tried and outcomes.*
8.	***Crohn's disease:*** Does the beneficiary have a history of trial and failure, contraindication, or intolerance of the following? ☐aminosalicylates ☐corticosteroids ☐immunomodulators	☐Yes ☐No *Submit documentation of all medications tried and outcomes.*
9.	***Crohn's disease:*** Does the Beneficiary have a history of trial and failure, contraindication, or intolerance of the preferred agent, **Humira**?	☐Yes ☐No *Submit documentation of all medications tried and outcomes.*
10.	***PEDIATRIC plaque psoriasis:*** Submit form to Pharmacy Services with documentation supporting the diagnosis.	
11.	***For all other diagnoses,*** submit documentation supporting the use of Stelara for the beneficiary's diagnosis & other treatments tried.	

RENEWAL requests

1.	Since starting Stelara, did the beneficiary experience a positive clinical response and/or improved level of functioning?	☐Yes ☐No *Submit documentation of clinical response.*

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	**Date**: