

## STELARA (ustekinumab) (non-preferred) PRIOR AUTHORIZATION FORM

Cytokine and CAM Antagonists and Quantity Limits/Daily Dose Limits prior authorization guidelines are accessible on the Department's Pharmacy Services website at <http://www.dhs.pa.gov/provider/pharmacyservices/index.htm>.

PRIOR AUTHORIZATION REQUEST INFORMATION		PRESCRIBER INFORMATION	
<input type="checkbox"/> New request	<input type="checkbox"/> Additional info	Total # of pages: _____	
<input type="checkbox"/> Renewal request	(PA#: _____)	Prescriber name: _____	
Name of office contact: _____		Specialty: _____	
Contact's phone number: _____		State license #: _____	
LTC facility contact/phone: _____		NPI: _____	MA Provider ID#: _____
RECIPIENT INFORMATION		Street address: _____	
Recipient Name: _____		Suite #: _____	City/state/zip: _____
Recipient ID#: _____	DOB: _____	Phone: _____	Fax: _____

### CLINICAL INFORMATION

<b>Product requested:</b>	<input type="checkbox"/> Stelara 45 mg/0.5 ml syringe	<input type="checkbox"/> Stelara 90 mg/ml syringe	<input type="checkbox"/> Stelara 130 mg/26 ml (5 mg/5 ml) vial
Directions: _____	Quantity: _____	Refills: _____	Recipient's weight: _____ lbs/kg
Diagnosis ( <i>submit documentation</i> ): _____			Diagnosis code ( <i>required</i> ): _____

#### ALL requests

- Specialty Pharmacy Drug Program:** What Specialty Pharmacy will be used?  Diplomat Specialty  Walgreens Specialty
- Check all that apply to the Recipient and *submit documentation for each*.
 

<input type="checkbox"/> screened for hepatitis B (antibody and/or surface antigen)	<input type="checkbox"/> up-to-date with all age-appropriate immunizations (if < 21 years of age, in accordance with EPSDT guidelines)
<input type="checkbox"/> screened for tuberculosis	

#### INITIAL requests – complete questions applicable to Recipient's diagnosis

- Psoriatic arthritis:** Does the Recipient have a history of trial and failure, contraindication, or intolerance of the following?
 

<input type="checkbox"/> 6-week trial each of at least 2 different NSAIDs	<input type="checkbox"/> 3-month trial of methotrexate/other DMARD	<input type="checkbox"/> Yes	<i>Submit documentation of all medications tried and outcomes – go to (7)</i>
		<input type="checkbox"/> No	
- Plaque psoriasis:** Does at least one of the following apply to the Recipient?
 

<input type="checkbox"/> at least 10% of body surface area (BSA) is affected	<input type="checkbox"/> critical areas of the body are involved (face, palms, soles, and/or genitals)	<input type="checkbox"/> Yes	<i>Submit documentation.</i>
		<input type="checkbox"/> No	
- Plaque psoriasis:** Does the Recipient have a history of trial and failure, contraindication, or intolerance of the following treatments? *Check all that apply.*

<input type="checkbox"/> PUVA	<input type="checkbox"/> UVB light with either coal tar or dithranol	<input type="checkbox"/> Yes	<i>Submit documentation of all treatments tried and outcomes.</i>
		<input type="checkbox"/> No	
- Plaque psoriasis:** Does the Recipient have a history of trial and failure, contraindication, or intolerance of a 3-month trial of the following medications? *Check all that apply.*

<input type="checkbox"/> acitretin	<input type="checkbox"/> cyclosporine	<input type="checkbox"/> methotrexate	<input type="checkbox"/> Yes	<i>Submit documentation of all medications tried and outcomes.</i>
			<input type="checkbox"/> No	
- Psoriatic arthritis and plaque psoriasis:** Does the Recipient have a history of trial and failure, contraindication, or intolerance of the preferred agents? *Check all that apply.*

<input type="checkbox"/> Enbrel	<input type="checkbox"/> Humira	<input type="checkbox"/> Yes	<i>Submit documentation of all medications tried and outcomes.</i>
		<input type="checkbox"/> No	
- Crohn's disease:** Does the Recipient have a history of trial and failure, contraindication, or intolerance of the following?
 

<input type="checkbox"/> aminosalicylates	<input type="checkbox"/> corticosteroids	<input type="checkbox"/> immunomodulators	<input type="checkbox"/> Yes	<i>Submit documentation of all medications tried and outcomes.</i>
			<input type="checkbox"/> No	
- Crohn's disease:** Does the Recipient have a history of trial and failure, contraindication, or intolerance of the preferred agent, Humira?
 

<input type="checkbox"/> Yes	<i>Submit documentation of all medications tried and outcomes.</i>
<input type="checkbox"/> No	

**For all other diagnoses, submit documentation supporting the use of the requested medication for the Recipient's diagnosis.**

#### RENEWAL requests

- Since starting Stelara, has the Recipient experienced a positive clinical response and/or improved level of functioning?
 

<input type="checkbox"/> Yes	<i>Submit documentation of clinical response.</i>
<input type="checkbox"/> No	

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

Prescriber Signature: _____	Date: _____
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