PriorityHealth

Pharmacy
PRIOR AUTHORIZATION FORM

Last Reviewed: Nov. 2011

For Prior Authorization, please fax toll-free (877) 974-4411, or local number (616) 942-8206

This from applies to: ☒ **Commercial Plan** ☒ **Medicaid Plan** ☒ **Medicare Plan**

Stelara® (ustekinumab)

Reset Form

☐ **URGENT** (life threatening)

☐ **Non-Urgent** (standard review)

A claim involving "urgent care" applies when then standard review time will seriously jeopardize the life or health of the member, or subject the member to severe pain that cannot be managed without the care or treatment requested in the subject of this request. **Priority Health averages between 1 and 3 business days for our standard review response time.**

Member Information

Member Name:	Member No.:
DOB: Gender:	
Member's PCP:	

PROVDER NAME:

Office Contact Name:	Provider Phone:
Provider NPI:	Provider Fax:
Provider Address:	

Provider Signature _____ Date _____

Prescriber is a dermatologist: ☐ **Yes** ☐ **No**

PRODUCT INFORMATION

NOTE: Stelara® is a non-preferred (non-formulary) specialty benefit. Stelara® is not covered unless the patient has met prior authorization criteria, including a documented therapeutic trial and clinical failure with Enbrel® or Humira® (prior authorization required).

☐ Stelara® single use vial, 45mg/0.5mL (<100 kg)
☐ Stelara® single use vial, 90mg/0.5mL (>100 kg)

Dose: _____
Start Date: _____

BILLING INFORMATION

Place of administration:

☐ Self-administered
☐ Provider's Office
☐ Outpatient Infusion Center
Center Name: _____
☐ Home Infusion
Agency Name: _____

Billing Options:
☐ Physician buy and bill
☐ Preferred Specialty Vendor
☐ Other: _____

Request:
☐ New
☐ Continuation

SECTION A – NEW THERAPY

PRIORITY HEALTH PRECERTIFICATION DOCUMENTATION
Authorization for Stelara® (ustekinumab) requires the following information to certify:

A. Patient has a diagnosis of:
- ☐ Moderate to severe Plaque Psoriasis ICD code: _____
  - ☐ Plaque affects > 10% of patient's body surface area (BSA)
  - ☐ Plaque psoriasis with < 10% BSA, but affects hands, feet, head, neck, intertriginous areas or genitalia
  - ☐ None of the above, rationale for use: _____
- ☐ Other: _____ ICD code: _____

If other, provide rationale for use: _____

B. Patient's age: _____ and weight: _____

C. Patient has a negative TB test result within the previous 12 months:
- ☐ Yes Date: _____
- ☐ No Rationale for not testing: _____

D. Patient has moderate to severe heart failure:
- ☐ No
- ☐ Yes – Rationale for use: _____

E. Patient had a therapeutic trial with at least one self-injectable anti-TNF agent:
- ☐ Yes *If yes, complete the following information:*
  - ☐ Enbrel Dates of treatment: _____
  - ☐ Humira Dosage taken: _____
  - ☐ Other: _____ Outcome: _____
- ☐ No
  - ☐ Patient has a history of hepatitis B or C (anti-TNF agents not required)
  - ☐ Patient has NYHA Class III or IV heart failure (anti-TNF agents not required)
  - ☐ Patient has demyelinating disease (e.g. multiple sclerosis, Guillain-Barré syndrome)
  - ☐ Other rationale: _____

F. Patient had a documented trial and clinical failure with at least one <u>topical agent</u>:
- ☐ Yes *If yes, complete the following information:*

  Drug: _____ Dates of treatment: _____

  Drug: _____ Dosage taken: _____

  Outcome: _____
- ☐ No – Rationale for use: _____

G. Patient had a documented trial of at least 3 months and/or inadequate response with <u>phototherapy</u> (UVA, UVB, PUVA):
- ☐ Yes *If yes, complete the following information:*

  Type of therpy: _____ Dates of therapy: _____
- ☐ No – Rationale for use: _____

H. Patient had a documented trial of at least 3 months and/or inadequate response with at least one systemic treatment (methotrexate, cyclosporine, Soriatane): *If yes, complete the following information:*

☐ Yes Dates of treatment: _____

Drug: _____ Dosage taken: _____

Drug: _____ Outcome: _____

☐ No

☐ Contraindicated: _____

☐ Rationale for use: _____

I. Please provide any other patient risk factors to consider: _____

SECTION B – CONTINUATION THERAPY

PRIORITY HEALTH PRECERTIFICATION DOCUMENTATION

Authorization for continuation of Stelara® (ustekinumab) requires the following information to certify:

For continuing authorization of Stelara®, all of the following criteria must be met:

☐ The patient is compliant in taking the medication as scheduled
☐ The patient tolerated the medication
☐ The patient did not experience any severe adverse reactions while taking the medication
☐ The patient has responded to treatment, as determined by the prescribing physician
☐ The patient has a negative TB test result within the past 12 months (**Date of test:** _____)

PRECERTIFICATION REQUIREMENTS

PRIORITY HEALTH PRECERTIFICATION REQUIRMENTS

Authorization for Stelara® (ustekinumab) requires the following information to certify:

Note: New approvals, when granted, will be for a 30 day supply per fill at once monthly for 3 months. Continued authorization will be approved for 12 months if the patient has responded to treatment, as determined by the prescriber.

1. **Patient must have a diagnosis of moderate to severe plaque psoriasis (BSA >10%) who are candidates for phototherapy or systemic therapy.**
2. **Patient must be 18 years of age or older**
3. **Patient must have a documented therapeutic trial with at least one self-injectable biologic agent (e.g. Enbrel, Humira)**, unless the patient has a diagnosis of New York Heart Association Class IV heart failure or a history of hepatitis B or C infection).
4. **Patient must have a negative TB test result within the past 12 months**
5. **Patient must have a trial of topical, systemic and phototherapy for at least 3 months.**
6. **Patient may not use Stelara in combination with other biologics** (e.g. Enbrel, Humira, Cimzia, Simponi, Remicade, Kineret, Amevive).

IMPORTANT INFORMATION: Live vaccines should not be given concurrently with Stelara or within 3 months of its discontinuation.

NOTE: Priority Health Medicare applies CMS local coverage determinations when available for Part B drugs. If no local coverage determination criteria is available for the state in which the member is receiving the services, the above prior authorization criteria must be met.

*** All fields must be complete and legible for Prior Authorization Review***

Please fax this request to: (877)974-4411 toll free or (616)942-8206

YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX

Print