PriorityHealth

Pharmacy Prior Authorization Form

For Prior Authorization, please fax to: 877 974-4411 toll free, or 616 942-8206

This form applies to: ☒ **Commercial (Traditional)** ☒ **Commercial Individual (Optimized)** ☐ **Medicaid**

This request is: ☐ **Urgent** (life threatening) ☐ **Non-Urgent** (standard review)

Urgent means the standard review time may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

Stelara® (ustekinumab)

Member

Last Name: _____ First Name: _____

ID #: _____ DOB: _____ Gender: _____

Primary Care Physician: _____

Requesting Provider: _____ Prov. Phone: _____ Prov. Fax: _____

Provider Address: _____

Provider NPI: _____ Contact Name: _____

Provider Signature: _____ Date: _____

☐ Dermatologist
☐ Rheumatologist
☐ Gastroenterologist

Product and Billing Information

☐ New request ☐ Continuation request

Drug product:
- ☐ Stelara 45 mg single-use syringe
- ☐ Stelara 90 mg single-use syringe
- ☐ Stelara 45 mg vial
- ☐ Stelara 130 mg vial for infusion

Start date (or date of next dose): _____
Date of last dose (if applicable): _____
Dose: _____
Frequency: _____
Patient's weight: _____

Place of administration:
- ☐ Self-administered
- ☐ Provider's office
- ☐ Outpatient infusion
  Facility: _____ NPI: _____ Fax: _____
- ☐ Home infusion
  Facility: _____ NPI: _____ Fax: _____

For **Crohn's disease**, will maintenance dosing be self-administered? ☐ Yes ☐ No

Billing:
- ☐ Preferred specialty vendor
- ☐ Physician to buy and bill
- ☐ Facility to buy and bill
- ☐ Specialty Pharmacy
  Pharmacy: _____ NPI: _____ Fax: _____

ICD code(s): _____

All fields must be complete and legible for review. Your office will receive a response via fax.

No changes made since 09/2018
Last reviewed 11/2018

STELARA COVERAGE POLICY

- Before Stelara is covered, the patient must meet all of the General Criteria for Stelara and all of the Specific Criteria for the treatment diagnosis. If these criteria are not met, the prescriber must provide an explanation of why an exception to the criteria is necessary.
- Coverage for a diagnosis not listed below will be considered on a case by case basis. Please provide rationale for use and all pertinent patient information.
- Stelara will not be covered in combination with a biologic drug.

Note: Authorization for indications, dosing, or a route of administration not approved by the Food and Drug Administration (FDA) or recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, U.S. Pharmacopeia, and also Clinical Pharmacology for oncology indications only) require supporting evidence for coverage. Please provide two published peer-reviewed literature articles supporting the appropriateness of the drug, the dosing of the drug, or the route of administration to be used for the identified indication.

Criteria

General Initiation Criteria for ALL Diagnoses:

a) Patient has evidence of a negative TB test result in the past 12 months (or TB is adequately managed); AND
b) Prescriber is a specialist or has consulted with a specialist for the condition being treated.

Specific Initiation Criteria for Individual Diagnoses:

1. Crohn's Disease
   a) Patient has tried or is currently taking corticosteroids (such as prednisone or methylprednisolone); OR
   b) Patient has tried at least ONE other agent for this condition (e.g., azathioprine, 6-mercaptopurine, methotrexate, Cimzia, Remicade, Entyvio, or Humira) for a period of at least 3 months.

2. Plaque Psoriasis
   a) Patient has tried **ALL** of the following for a period of at least 3 months:
      a. One topical agent
      b. One traditional non-biologic systemic agent (e.g., methotrexate [MTX], cyclosporine, acitretin)
      c. Phototherapy
   b) If 90 mg dose is requested, patient must weigh more than 100 kg

3. Psoriatic Arthritis
   a) Patient has tried at least ONE conventional systemic DMARD (such as methotrexate, leflunomide, sulfasalazine, or azathioprine) for a period of at least 3 months.
   b) If 90 mg dose is requested, patient must weigh more than 100 kg

Additional information

When used for plaque psoriasis and psoriatic arthritis, Stelara will initially be approved for the 45 mg dose only, regardless of the patient's weight.

Request to increase dosing to the 90 mg (for patients greater than 100 kg only):

1. Must have tried Stelara 45 mg for at least 12 weeks
2. Documentation must be provided that shows that the patient's condition has not improved after 12 weeks with the 45 mg dose.

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Priority Health Precertification Documentation

A. What condition is this drug being requested for?

- ☐ Crohn's disease
- ☐ Plaque psoriasis
- ☐ Psoriatic arthritis
- ☐ Other – the patient's condition is: _____

  Rationale for use: _____

B. Which of the following has the patient had a documented therapeutic trial with?

- ☐ Prednisone Dates of therapy: _____
- ☐ Methylprednisolone Dates of therapy: _____
- ☐ Azathioprine Dates of therapy: _____
- ☐ 6-Mercaptopurine Dates of therapy: _____
- ☐ Methotrexate Dates of therapy: _____
- ☐ Cyclosporine Dates of therapy: _____
- ☐ Acitretin Dates of therapy: _____
- ☐ Cimzia Dates of therapy: _____
- ☐ Enbrel Dates of therapy: _____
- ☐ Entyvio Dates of therapy: _____
- ☐ Humira Dates of therapy: _____
- ☐ Remicade Dates of therapy: _____
- ☐ Simponi Dates of therapy: _____
- ☐ Cosentyx Dates of therapy: _____
- ☐ Other Drug: _____ Dates of therapy: _____

C. Has the patient had a negative TB test result in the past 12 months?

- ☐ Yes Date: _____
- ☐ No, rationale for use: _____

D. Does the patient have moderate to severe heart failure?

- ☐ Yes Date: _____
- ☐ No, rationale for use: _____

E. Will the patient be receiving other biologic therapy in combination with Stelara?

- ☐ No ☐ Yes, rationale for use: _____

The following questions are required for **plaque psoriasis** only:

F. Has the patient had a trial with one or more topical agents for a period of at least 3 months?

- ☐ Yes
- ☐ No – rationale for use: _____

G. Has the patient had a trial with phototherapy for a period of at least 3 months?

- ☐ Yes, UVA
- ☐ Yes, UVB
- ☐ No – rationale for use: _____

H. Has the patient had a trial with one or more non-biologic systemic agents for a period of at least 3 months?

- ☐ No – rationale for use: _____
- ☐ Yes – Please mark the agent(s) tried and failed above.

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Last reviewed 11/2018