PriorityHealth

Priority Health Medicare prior authorization form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☐ **Medicare Part B** ☒ **Medicare Part D**

This request is: ☐ **Expedited request** ☐ **Standard request**

Your request will be expedited if you haven't gotten the prescription and Priority Health Medicare determines, or your prescriber tells us, that your life or health may be at risk by waiting.

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

Product and Billing Information

☐ New request ☐ Continuation request - **Original therapy start date**: ____________________

Drug product:

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

Date of last dose (if applicable): ____________________

Date of next dose (if applicable): ____________________

Dose:__________ **Dose Frequency**:____________________

Patient's weight: ____________________

Number of doses requested: ____________

HCPCS Code: ____________________

Place of administration:

- ☐ Physician's office
- ☐ Outpatient infusion
  Facility: ____________ NPI:____________ Fax:____________
- ☐ Home infusion
  Facility: ____________ NPI:____________ Fax:____________

Billing:

- ☐ Physician to buy and bill
- ☐ Facility to buy and bill
- ☐ Specialty Pharmacy
  Pharmacy:____________ NPI:____________ Fax:____________

ICD-10 Diagnosis code(s): ____________________

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

No changes made since 01/2019
Last reviewed 01/2019

Precertification Requirements

The following requirements need to be met before this drug is covered by Priority Health Medicare. These requirements have been approved by the Centers for Medicare and Medicaid Services (CMS), but you may ask us for an exception if you believe one or more of these requirements should be waived

Patient must meet all of the following criteria:

1. Must be used for a medically-accepted indication*
2. For plaque psoriasis
   - Must have ≥ 5% body surface area affected (unless hands, feet, head, neck, or genitalia affected)
   - Must first try one non-biologic DMARD
   - Must first try Enbrel or Humira
3. For psoriatic arthritis
   - Must first try one non-biologic DMARD
   - Must first try Enbrel or Humira
4. Crohn's disease
   - Must first try or be intolerant to Humira
   - For patients who are naïve to treatment with a TNF blocker, must first try or be intolerant to one immunomodulator (methotrexate, azathioprine, 6-MP) or one corticosteroid
5. Must have a negative TB test (must be done yearly)
6. Must be age 12 or older

NOTE: The FDA-approved dosing for Crohn's disease is a single weight-based intravenous infusion of Stelara followed by subcutaneous maintenance dosing of 90 mg every 8 weeks.

Medically-accepted indication*

This drug is only covered under Medicare Part D when it is used for a medically accepted indication. A medically accepted indication is a use of the drug that is *either*:

- approved by the Food and Drug Administration. (That is, the Food and Drug Administration has approved the drug for the diagnosis or condition for which it is being prescribed.)
- — *or* — supported by certain reference books. (These reference books are the American Hospital Formulary Service Drug Information and the DRUGDEX Information System)

Priority Health Precertification Documentation

A. What is the date and result of the patient's most recent TB test?

☐ Negative **Date:** ____________________

☐ Positive

☐ Not completed. **Are you requesting an exception to the criteria?**

☐ Yes. ***Rationale for exception***: ________________________________

☐ No

B. What is the patient's condition?

☐ Plaque psoriasis

1. Does the patient's psoriasis affect one of the following?

☐ ≥ 5% body surface area ☐ feet

☐ hands ☐ neck

☐ genitalia ☐ head

☐ None. **Are you requesting an exception to the criteria?**

☐ Yes. ***Rationale for exception***: ________________________________

☐ No

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2. **Has the patient had a trial with a non-biologic DMARD?**
   - ☐ Yes.
   - ☐ No. **Are you requesting an exception to the criteria?**
     - ☐ Yes. ***Rationale for exception***: ______________________________
     - ☐ No

3. **Did the patient try Enbrel or Humira?**
   - ☐ Yes.
   - ☐ No. **Are you requesting an exception to the criteria?**
     - ☐ Yes. ***Rationale for exception***: ______________________________
     - ☐ No

☐ Psoriatic arthritis

1. **Has the patient had a trial with a non-biologic DMARD?**
   - ☐ Yes.
   - ☐ No. **Are you requesting an exception to the criteria?**
     - ☐ Yes. ***Rationale for exception***: ______________________________
     - ☐ No

2. **Did the patient try Enbrel or Humira?**
   - ☐ Yes.
   - ☐ No. **Are you requesting an exception to the criteria?**
     - ☐ Yes. ***Rationale for exception***: ______________________________
     - ☐ No

☐ Crohn's disease

1. **Did the patient try or is intolerant to Humira?**
   - ☐ Yes.
   - ☐ No. **Are you requesting an exception to the criteria?**
     - ☐ Yes. ***Rationale for exception***: ______________________________
     - ☐ No

2. **Is the patient naïve to treatment with a TNF blocker and has tried or is intolerant to an immunomodulator (methotrexate, azathioprine, 6-MP) or a corticosteroid?**
   - ☐ Yes.
   - ☐ No. **Are you requesting an exception to the criteria?**
     - ☐ Yes. ***Rationale for exception***: ______________________________
     - ☐ No

Priority Health Medicare Exception Request *(exceptions to the above criteria)*

Do you believe one or more of the prior authorization requirements should be waived? ☐ Yes ☐ No
If yes, you must provide a statement explaining the medical reason why the exception should be approved.

Would Stelara likely be the most effective option for this patient?
☐ Yes ☐ No
If yes, please explain why: ______________________________

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If the patient is currently using Stelara, would changing the patient's current regimen likely result in adverse effects for the patient?
☐ Yes ☐ No
If yes, please explain: ______________________________

____

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Last reviewed 01/2019