Please Note: Medical Necessity Prior Authorization may be overrided for both formulary coverage and benefit design restrictions. They are issued at the full discretion of the benefit manager.

PRIOR AUTHORIZATION **BYPASS**

Stelara® (usetekinumab)

Bypass the Prior Authorization by Modifying the following Prescription Forms to the Patient's Needs

Name _____

Address _____

℞

REFER FOR PSORIASIS PROTOCOL

MD _____

Signature _____

Name _____

Address _____

℞ Naltrexone 1% topical
quantity #
sig: apply to affected area 2x/dy

as directed by physician

Dx: PSORIASIS

ICD 10: L 40.9

MD _____

Signature _____

Prescriber Information

Last Name:	First Name
DEA/NPI:	Specialty:
Phone	Fax

Member Information

Last Name:	First Name
Member ID Number	DOB:

Medication Information:

Drug Name and Strength:	Quantity and Dosing:
Diagnosis:	Duration:

When advised below, please include all requested fax documentation (lab results, etc.) when submitting this Prior Authorization fax form; not submitting requested documentation could delay the clinical review process.

Stelara Prior Authorization Form

You must answer ALL of the following questions		
1. Is the patient 18 years of age or older?	Y	N
2. Will the medication be used concurrently with a TNF inhibitor?	Y	N
3. Has the patient tried and had an inadequate response to a three-month trial with Enbrel (etanercept) AND Humira (adalimumab)? *Please provide supporting documentation, including trial dates.*	Y	N
4. What is the patient's diagnosis? **(Please Circle)** • Moderate to severe psoriatic arthritis • Plaque psoriasis • Other: _____		
PSORIATIC ARTHRITIS		
5. Is the medication prescribed by a rheumatologist or dermatologist?	Y	N
6. Has the patient had at least a 3-month trial and failure with an oral non-biologic disease modifying anti-rheumatic agent (DMARD) (e.g., methotrexate, azathioprine (Imuran), auranofin (Ridaura), hydroxychloroquine (Plaquenil), penicillamine (Cuprimine), sulfasalazine (Azulfidine), leflunomide (Arava))? *Please provide supporting documentation, including which agents have been tried and trial dates.*	Y	N
PLAQUE PSORIASIS		
5. Is the medication prescribed by a dermatologist?	Y	N

6. Does the patient have plaques covering greater than or equal to 3% of their body surface area (BSA) or less than 3% of BSA with involvement of palms, soles, head and neck, or genitalia which causes disruption of normal activities?	Y	N
7. Has the patient had an inadequate response or intolerance to topical therapy (e.g., corticosteroids, anthralin, calcipotriene, tazarotene)? *Please provide supporting documentation, including which agent(s) have been tried and trial dates.*	Y	N
8. Has the patient had an inadequate response to previous treatment with one of the following phototherapies? • Psoralens with UVA light (PUVA) • UVB with coal tar *Please provide supporting documentation, including which agent(s) have been tried and trial dates.*	Y	N
9. Has the patient tried and had an inadequate response, intolerance, or contraindication to at least one of the following systemic therapies? • Acitretin • Methotrexate • Cyclosporine *Please provide supporting documentation, including which agent(s) have been tried and trial dates.*	Y	N

Please note, not all drugs/diagnoses are covered on all plans.

Comments: _____

Information given on this form is accurate as of this date.

Prior Authorization forms are located on the Cover Page. Print a new form for each request as forms are updated periodically.

_____ _____

Prescriber or Authorized Signature **Date**

_____

Authorized Medical Staff – Name/Title

Attention Healthcare Provider: If you would like to discuss this request with a medical professional, please contact the Prior Authorization Department whose numbers appear on the Cover Page.

I understand that USDoctor's use or disclosure of individually identifiable health information, whether furnished by me or obtained by another source such as medical providers, shall be in accordance with federal privacy regulations under HIPAA (Health Insurance Portability and Accountability Act of 1996).

Contact Information:

Telephone: (855)251.9116
Fax: (248)593.9575

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PRIOR AUTHORIZATION FORM:
COVER PAGE

MEMBER INFORMATION			
First Name		**Last Name**	
Plan			
Member ID		**Date of Birth**	

DRUG INFORMATION			
Drug Name			
Quantity		**ICD-10**	
Directions		**Duration of Therapy**	
Diagnosis			

PLEASE LIST ALTERNATIVE THERAPIES THAT HAVE BEEN ATTEMPTED AND ANY OTHER PERTINENT INFORMATION RELATED TO DRUG AND/OR DISEASE STATE. IF NOT PRESENT, WITHIN NORMAL LIMITS WILL BE USED FOR THE REVIEW.

Medication/Failure Reason:

IgE:_____

ESR:_____ **CRP:**_____ **# Joints:**_____ **%BSA:**_____

Height:_____ **Weight:**_____ **BMI:**_____

HA1C:_____ **Hemoglobin:**_____ **Hematocrit:**_____ **T-Score:**_____

Dialysis:_____ **Long Term Care Facility:**_____ **Self Injecting:**_____

Stimulation test:_____/_____ **Growth velocity:**_____ **#Chemotherapy cycles/month:**_____

Mini-Mental Status Test:_____ **Baseline Free testosterone/Total testosterone:**_____/_____

HCV RNA viral load:_____ **Viral Genotype:**_____ **ALT:**_____

PHYSICIAN INFORMATION			
Physician Signature		**Date**	
Physician Name		**NPI #**	
Phone Number		**Fax Number**	
Action Needed	Only mark Urgent when standard review time would seriously harm the member's life or health or ability to regain maximum function ☐ Urgent ☐ For Review	**Pharmacy Fax**	