



## Stelara (ustekinumab) Prior Authorization of Benefits Form

**CONTAINS CONFIDENTIAL PATIENT INFORMATION**

**Complete form in its entirety and fax to: Prior Authorization of Benefits Center at 844-474-3341**

**1. Patient information**

**2. Physician information**

Patient name: _____	Prescribing physician: _____
Patient ID #: _____	Physician address: _____
Patient DOB: _____	Physician phone #: _____
Date of Rx: _____	Physician fax #: _____
Patient phone #: _____	Physician specialty: _____
Patient email address: _____	Physician DEA: _____
	Physician NPI #: _____
	Physician email address: _____

**3. Medication**

**4. Strength**

**5. Directions**

**6. Quantity per 30 days**

Stelara (ustekinumab)			Specify:
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**7. Diagnosis** \_\_\_\_\_

**8. Approval criteria:** Item (Check all boxes that apply. Note: Any areas not filled out are considered not applicable to your patient and may affect the outcome of this request.)

<input type="checkbox"/> Yes <input type="checkbox"/> No	Is medication is being provided and billed at the physician’s office?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Patient has had a diagnosis of plaque psoriasis and/or psoriatic arthritis in the last 730 days.
<input type="checkbox"/> Yes <input type="checkbox"/> No	Patient has had a diagnosis of Crohn’s disease in the last 730 days.
<input type="checkbox"/> Yes <input type="checkbox"/> No	Patient had at least 30 days therapy for an immunomodulator, corticosteroid or tumor necrosis factor (TNF) blocker in the last 180 days. (PLEASE NOTE: Immunomodulators, Corticosteroids, and TNF blockers are: azathioprine, Cimzia, Cortef, cyclosporine, cyclosporine modified, dexamethasone, dexamethasone intensol, Enbrel, Gengraf, Humira, hydrocortisone, Imuran, Medrol, mercaptopurine,

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methotrexate, methylprednisolone, Millipred, Neoral, Otrexup, prednisolone, prednisolone ODT, prednisone, Purixan, Sandimmune, Simponi, Simponi Aria, Trexall, Veripred and Xatmep.)

Yes  No Patient has had a serious active infection (including hepatitis B virus and/or tuberculosis) in the last 180 days.

Yes  No Patient has failed a 30-day treatment trial with at least one preferred agent(s) within the past 180 days. (PLEASE NOTE: The preferred agents include Enbrel and Humira.)

Yes  No Patient has a documented allergy or contraindication to preferred agents in this class. (PLEASE NOTE: The preferred agents include Enbrel and Humira.)

Yes  No Does the client have a diagnosis of ulcerative colitis in the last 730 days?

For the *Texas Medicaid Preferred Drug List*, please refer to the Texas Medicaid Vendor Drug Program website at <http://www.txvendordrug.com/formulary/formulary-search.asp>.

**9. Physician signature**

Prescriber or authorized signature	Date
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*Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations and exclusions. The submitting provider certifies that the information provided is true, accurate and complete and the requested services are medically indicated and necessary to the health of the patient. Note: Payment is subject to member eligibility. Authorization does not guarantee payment.*

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