FUTURE SCRIPTS

Please complete ALL information below and fax your request to 1-888-671-5285

Stelara® Prior Authorization Request Form (Page 1 of 2)

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if **generic substitution** is acceptable ❑ Check if request is for **continuation of therapy**	Directions for Use:	

Clinical Information (required)

Select the diagnosis below:

❑ Crohn's disease (for example: K50.00, K50.919, K50.019)
❑ Plaque psoriasis (for example: psoriasis vulgaris, psoriasis; L40.0, L40.8, L40.9)
❑ Psoriatic arthritis (for example: arthropathic psoriasis; L40.5, L40.59)
❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical Information:

Please document the patient's weight: _____lbs/kg

Select if Stelara is prescribed by or in consultation with one of the following specialists:
❑ Dermatologist ❑ Gastroenterologist ❑ Rheumatologist

Is the patient receiving Stelara in combination with a biologic DMARD (e.g., Enbrel [etanercept], Humira [adalimumab], Cimzia [certolizumab], Simponi [golimumab])? ❑ **Yes** ❑ **No**

Crohn's Disease:

Does the patient have moderately to severely active disease? ❑ **Yes** ❑ **No**

Has the patient had trial and failure, contraindication or intolerance to at least one tumor necrosis factor (TNF) blocker (e.g., Remicade/Inflectra [infliximab], Humira [adalimumab], Cimzia [certolizumab pegol])? ❑ **Yes** ❑ **No**

Has the patient had trial and failure, contraindication or intolerance to treatment with at least one immunomodulator or corticosteroid (e.g., Purinethol [6-mercaptopurine], Imuran [azathioprine], Sandimmune [cyclosporine A], Prograf [tacrolimus], MTX [methotrexate])? ❑ **Yes** ❑ **No**

Is this for continuation of prior Stelara therapy? ❑ **Yes** ❑ **No**

For intravenous (IV) Stelara, answer the following:

Is Stelara to be administered as an intravenous induction dose? ❑ **Yes** ❑ **No**

Select the induction dosing that will be used in accordance with the United States Food and Drug Administration approved labeled dosing for Crohn's disease:
❑ 260 mg for patients weighing 55 kg or less
❑ 390 mg for patients weighing more than 55 kg to 85 kg
❑ 520 mg for patients weighing more than 85 kg

Plaque Psoriasis:

Does the patient have moderate to severe disease? ❑ **Yes** ❑ **No**

Psoriatic Arthritis:

Does the patient have active disease? ❑ **Yes** ❑ **No**

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Reauthorization:

Is there documentation the patient has had a positive clinical response to Stelara therapy? ❑ **Yes** ❑ **No**

Is the patient receiving Stelara in combination with a biologic DMARD (e.g., Enbrel [etanercept], Humira [adalimumab], Cimzia [certolizumab], Simponi [golimumab])? ❑ **Yes** ❑ **No**

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.