



**Stelara (Ustekinumab)
Prior Authorization Request Form**



Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

URGENT

MEMBER INFORMATION		
LAST NAME:	FIRST NAME:	
PHONE NUMBER:	DATE OF BIRTH:	
STREET ADDRESS:		
CITY:	STATE:	ZIP CODE:
PATIENT INSURANCE ID NUMBER:		

MALE FEMALE HEIGHT (IN/CM): _____ WEIGHT (LB/KG): _____ ALLERGIES: _____

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: [HTTPS://MAGELLANRX.COM/MEMBER/EXTERNAL/COMMERCIAL/COMMON/DOC/EN-US/PHI_DISCLOSURE_AUTHORIZATION.PDF](https://MAGELLANRX.COM/MEMBER/EXTERNAL/COMMERCIAL/COMMON/DOC/EN-US/PHI_DISCLOSURE_AUTHORIZATION.PDF)

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): _____
 AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: _____

PRESCRIBER INFORMATION	
LAST NAME:	FIRST NAME:
PRESCRIBER SPECIALTY:	EMAIL ADDRESS:
NPI NUMBER:	DEA NUMBER:
PHONE NUMBER:	FAX NUMBER:
STREET ADDRESS:	
CITY:	STATE: ZIP CODE:
REQUESTOR (if different than prescriber):	OFFICE CONTACT PERSON:

MEDICATION OR MEDICAL DISPENSING INFORMATION			
MEDICATION NAME:			
DOSE/STRENGTH:	FREQUENCY:	LENGTH OF THERAPY/REFILLS:	QUANTITY:
<input type="checkbox"/> NEW THERAPY	<input type="checkbox"/> RENEWAL	IF RENEWAL: DATE THERAPY INITIATED:	
DURATION OF THERAPY (SPECIFIC DATES):			

Continued on next page.





**Stelara (Ustekinumab)
Prior Authorization Request Form**



Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

MEMBER'S LAST NAME: _____ MEMBER'S FIRST NAME: _____

1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? YES (if yes, complete below) NO

MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE):	DURATION OF THERAPY (SPECIFY DATES):	RESPONSE/REASON FOR FAILURE/ALLERGY:
---	---	---

2. LIST DIAGNOSES: **ICD-10:**

<input type="checkbox"/> Crohn's disease <input type="checkbox"/> Moderate to severe psoriatic arthritis <input type="checkbox"/> Plaque psoriasis <input type="checkbox"/> Other Diagnosis _____ ICD-10 Code(s): _____	
--	--

3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.

For all diagnoses, answer the following:
Will Stelara be used concurrently with a TNF inhibitor? Yes No

Select if Stelara is being prescribed by one of the following specialists:

- Dermatologist
- Gastroenterologist
- Rheumatologist

For Crohn's disease, also answer the following:
Will Stelara be used concurrently with another biologic response modifier? Yes No

Select if the patient has tried and had an inadequate response, intolerance, or contraindication to the following systemic therapies:

- Glucocorticoid therapy
- Methotrexate
- Azathioprine
- 6-mercaptopurine
- 5-ASA/mesalamine

Please provide supporting documentation, including which agent(s) have been tried and trial dates: _____

Has the patient tried and had an inadequate response to a three-month trial with Humira (adalimumab)?*
 Yes No

**Please provide supporting documentation, including trial dates.*

Select if the patient has a contraindication to all of the following pre-requisite medications or there is a reason why the patient cannot take the following:

- Systemic therapy: Glucocorticoid therapy, Methotrexate, Azathioprine, 6-mercaptopurine, and 5-ASA/mesalamine
 - Humira (adalimumab)
- Please provide clinical rationale:** _____





**Stelara (Ustekinumab)
Prior Authorization Request Form**



Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

For moderate to severe psoriatic arthritis, also answer the following:

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, sulfasalazine (Azulfidine), leflunomide (Arava), cyclosporine)? Yes No

If "yes" to the above question, please provide supporting documentation, including which agent(s) have been tried and trial dates: _____

Has the patient tried and had an inadequate response to a three-month trial with Enbrel (etanercept)?* Yes No

**Please provide supporting documentation, including trial dates.*

Has the patient tried and had an inadequate response to a three-month trial with Humira (adalimumab)?* Yes No

**Please provide supporting documentation, including trial dates.*

For plaque psoriasis, also answer the following:

Does the patient have plaques covering greater than or equal 3% of their body surface area (BSA)? Yes No

Does the patient have plaques covering less than 3% of their BSA with involvement of palms, soles, head and neck, or genitalia which causes disruption of normal activities? Yes No

Has the patient has had an inadequate response to previous treatment with phototherapy? Yes No

Please provide supporting documentation, including which agent(s) have been tried and trial dates: _____

Select if the patient has tried and had an inadequate response, intolerance, or contraindication to the following systemic therapies:

- Acitretin
- Methotrexate
- Cyclosporine

Please provide supporting documentation, including which agent(s) have been tried and trial dates: _____

Has the patient tried and had an inadequate response to a three-month trial with Enbrel (etanercept)?* Yes No

**Please provide supporting documentation, including trial dates.*

Has the patient tried and had an inadequate response to a three-month trial with Humira (adalimumab)?* Yes No

**Please provide supporting documentation, including trial dates.*

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: Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received.





**Stelara (Ustekinumab)
Prior Authorization Request Form**



Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature or Electronic I.D. Verification: _____ **Date:** _____

CONFIDENTIALITY NOTICE: The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately (via return FAX) and arrange for the return or destruction of these documents.

FAX THIS FORM TO: 800-424-7640

MAIL REQUESTS TO: Magellan Rx Management Prior Authorization Program; c/o Magellan Health, Inc.
4801 E. Washington Street, Phoenix, AZ 85034
Phone: 877-228-7909

