



**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.*





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MEMBER'S LAST NAME: \_\_\_\_\_ MEMBER'S FIRST NAME: \_\_\_\_\_

<b>1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION?</b> <input type="checkbox"/> YES (if yes, complete below) <input type="checkbox"/> NO		
<b>MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE):</b>  	<b>DURATION OF THERAPY (SPECIFY DATES):</b>  	<b>RESPONSE/REASON FOR FAILURE/ALLERGY:</b>  
<b>2. LIST DIAGNOSES:</b> <input type="checkbox"/> Crohn's disease <input type="checkbox"/> Moderate to severe psoriatic arthritis <input type="checkbox"/> Plaque psoriasis <input type="checkbox"/> Ulcerative colitis <input type="checkbox"/> Other Diagnosis: _____ ICD-10 Code(s): _____		<b>ICD-10:</b>  
<b>3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.</b>		
<p><b>"Patients previously started on intravenous Stelara must meet all Plan criteria before subcutaneous Stelara will be approved for benefit coverage."</b></p> <p><b>For <u>all diagnoses</u>, answer the following:</b></p> <p><b>Will Stelara be used concurrently with another biologic or immunomodulatory agent?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>Has the patient tried and had an inadequate response to a three-month trial with the biosimilar for Humira – adalimumab-aacf?*</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <i>*Please provide supporting documentation, including trial dates.</i></p> <p><b>Select if Stelara is being prescribed by one of the following specialists:</b></p> <input type="checkbox"/> Dermatologist <input type="checkbox"/> Gastroenterologist <input type="checkbox"/> Rheumatologist <p><b>For <u>Crohn's disease</u>, also answer the following:</b></p> <p><b>Select if the patient has tried and had an inadequate response, intolerance, or contraindication to the following systemic therapies:</b></p> <input type="checkbox"/> Glucocorticoid therapy <input type="checkbox"/> Methotrexate <input type="checkbox"/> Azathioprine <input type="checkbox"/> 6-mercaptopurine <input type="checkbox"/> 5-ASA/mesalamine <p><b>Please provide supporting documentation, including which agent(s) have been tried and trial dates:</b> _____</p>		





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MEMBER'S LAST NAME: \_\_\_\_\_ MEMBER'S FIRST NAME: \_\_\_\_\_

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
- adalimumab-aacf

Please provide clinical rationale: \_\_\_\_\_

**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: \_\_\_\_\_

**For plaque psoriasis, also answer the following:**

Does the patient have plaques covering greater than or equal 10% of their body surface area (BSA)?  Yes  No

Does the patient have plaques covering less than 10% 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: \_\_\_\_\_

**For Ulcerative Colitis, also answer the following:**

Is the request for maintenance therapy ONLY (NOT INDUCTION THERAPY)?  Yes  No

Has patient tried and failed at least one of the following three therapies: corticosteroids, azathioprine and/or 6-mercaptopurine?  Yes  No *\*Please provide supporting documentation, including trial dates.*

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

- Dermatologist
- Gastroenterologist
- Rheumatologist





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**Is patient continuing to respond to therapy?**  Yes  No *Please submit documentation.*

**Will patient use requested medication in combination with another biologic response modifier or immunomodulatory agent?**  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?**

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

**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  
 Attn: CP – 4201  
 P.O. Box 64811  
 St. Paul, MN 55164-0811

