

Pharmacy Request for Prior Approval – Stelara Injection

Beneficiary Information				
1. Beneficiary Last Name:				
3. Beneficiary ID #:	4. Beneficiary Date of Birth:		5. Beneficiary	Gender:
Prescriber Information				
6. Prescriber Name:				
Mailing address:				 _ ZIP:
7. Requester Contact Information:				
Name:	Phone #:		Fax #:	
Drug Information				
	9. Dose:	10. Dir	ections:	
11. Length of Therapy:up to 30 days6				
Clinical Information				
Request for Crohn's Disease (Adult):	and and the server Cook of Disc	2 V	Nie	
1. Does the beneficiary have a diagnosis of n		ase? Yes	_ NO	
2. Is the beneficiary 18 years of age or older		N1 -		
3. Is the beneficiary on another injectable bi				
4. Has the beneficiary been considered and			osis intection? Yes No	0
5. Has the beneficiary been tested with Hep				Na
6. Has the beneficiary had a trial and failure	of Humira, or a clinical reason b	eneliciary ca	nnot try numira? Yes	_ NO
Request for Plaque Psoriasis (Adult):				
1. Does the beneficiary have a documented	_	e-to-severe C	hronic Plaque Psoriasis?	Yes No
2. Is the beneficiary 18 years of age or older		N1 -		
3. Is the beneficiary on another injectable bi			and the facility of the second	
4. Has the beneficiary been considered and s	· ·		osis infection? Yes No	0
5. Has the beneficiary been tested with Hep			No	
6. Does the beneficiary have a body surface7. Does the beneficiary have involvement of		_		ermal daily activities
and/or employment? Yes No	the paints, soles, head and heck	, or germana	i, causing distuption in no	irinal daily activities
8. Has the beneficiary failed to respond to, or	or has been unable to tolerate of	nototherany	and ONE of the following	medications or
beneficiary has contraindications to these tr			_	
9. Has the beneficiary had a trial and failure				
Humira? Yes No	• •		,	, , ,
Request for Plaque Psoriasis (Pediatric): (Ag	ges 6 & up)			
1. Does the beneficiary have a diagnosis of p	= -	te for system	nic therapy or photothera	py? Yes No
2. Is the beneficiary on another injectable bi		-	., .	.,
3. Has the beneficiary been considered and	screened for the presence of late	ent tubercul	osis infection? Yes No	0
4. Has the beneficiary been tested with Hep	B SAG and Core Ab? Yes No)		
5. Has the beneficiary experienced a therape	eutic failure/inadequate respons	e with or ha	s a contraindication or int	colerance to
methotrexate? Yes No				
6. Does the beneficiary have a body surface		_		
7. Does the beneficiary have involvement of	the palms, soles, head and neck	t, or genitalia	a, causing disruption in no	ormal daily activities
and/or employment? Yes No				
8. Has the beneficiary had a trial and failure	of Cosentyx or Enbrel or a clinical	al reason be	neficiary cannot try Cosen	ityx or Enbrel?
Yes No				
Request for Psoriatic Arthritis:				
1. Does the beneficiary have a documented		Arthritis? Yo	ès No	
2. Is the beneficiary 6 years of age or older?				
3. Is the beneficiary on another injectable bi	_			
4. Has the beneficiary been considered and			osis infection? Yes No	0
5. Has the beneficiary been tested with Hep				
6. Does the beneficiary have a documented	inageguate response or inability	to take met	notrexate? Yes No	



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North Carolina

	7. For beneficiaries 18 years of age or older: Has the beneficiary had a trial and failure of Cosentyx, Enbrel or Humira or a clinical reason	
	beneficiary cannot try Cosentyx, Enbrel or Humira? Yes No 8. For beneficiaries 6 years of age to 17 years of age: Has the beneficiary had a trial and failure of Cosentyx, or a clinical reason	
	beneficiary cannot try Cosentyx? Yes No	
	Request for Ulcerative Colitis (Adult):	
	1. Does the beneficiary have a diagnosis of ulcerative colitis? Yes No	
	2. Is the beneficiary 18 years of age or older? Yes No	
	3. Is the beneficiary on another injectable biologic immunomodulator? Yes No	
	4. Has the beneficiary been considered and screened for the presence of latent tuberculosis infection? YesNo	
	5. Has the beneficiary been tested with Hep B SAG and Core Ab? Yes No 6. Has the beneficiary had a trial and failure of Humira, or a clinical reason beneficiary cannot try Humira? Yes No	
	Request for FDA Approved Diagnosis Not Listed Above:	
	1. Diagnosis:	
	2. Is the beneficiary on another injectable biologic immunomodulator? Yes No	
	3. Has the beneficiary been considered and screened for the presence of latent tuberculosis infection? Yes No	
ı	4. Has the beneficiary been tested with Hep B SAG and Core Ab? Yes No	
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*Prescriber signature mandatory

Signature of Prescriber:

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Date: _____