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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 1-844-474-3341.

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 (usteminumab)			Specify:
7. Diagnosis:			

8. Approval criteria: (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.)

☐ Yes ☐ No Is medication is being provided and billed at the physician’s office?
☐ Yes ☐ No Patient has had a diagnosis of plaque psoriasis and/or psoriatic arthritis in the last 730 days.
☐ Yes ☐ No Patient has had a diagnosis of Crohn’s disease in the last 730 days.
☐ Yes ☐ 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, 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.

Patient name: ________________________________ Patient ID #: _____________________

(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 **https://www.txvendordrug.com/formulary/prior-authorization/preferred-drugs**.

9. Physician signature

____ _________________________________

Prescriber or authorized signature Date

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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