

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

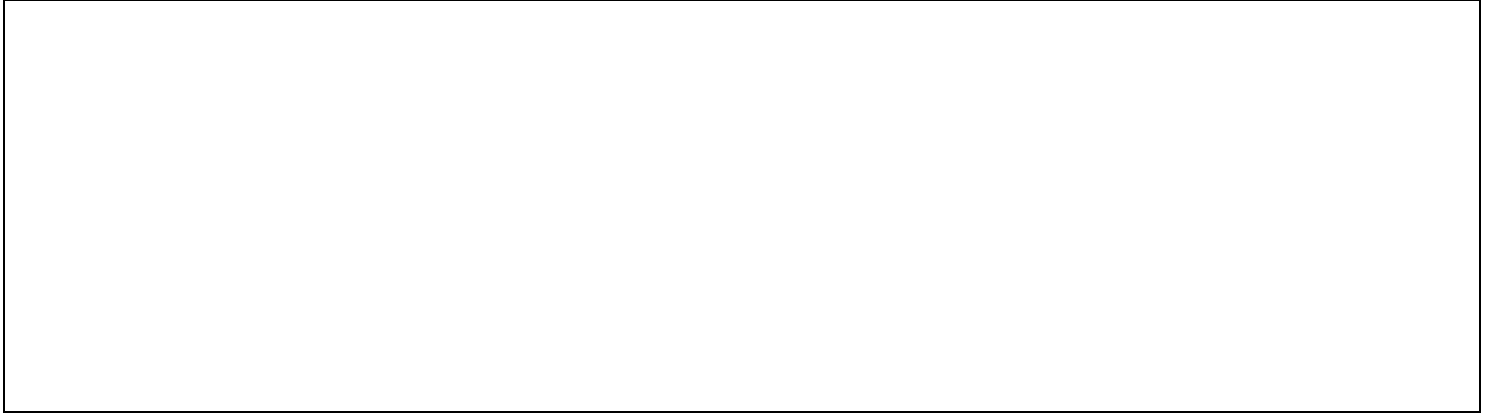
Member Information <small>(required)</small>			Provider Information <small>(required)</small>		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:		Specialty:
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:
Medication Information <small>(required)</small>					
Medication Name:			Strength:		Dosage Form:
<input type="checkbox"/> Check if requesting brand			Directions for Use:		
<input type="checkbox"/> Check if request is for continuation of therapy					
Clinical Information <small>(required)</small>					
Select the diagnosis below: <input type="checkbox"/> Active psoriatic arthritis <input type="checkbox"/> Moderate to severe plaque psoriasis <input type="checkbox"/> Moderately to severely active Crohn's disease <input type="checkbox"/> 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: <input type="checkbox"/> Dermatologist <input type="checkbox"/> Gastroenterologist <input type="checkbox"/> Rheumatologist Is the patient receiving Stelara in combination with a biologic DMARD [e.g., Enbrel (etanercept), Humira (adalimumab), Cimzia (certolizumab), Simponi (golimumab)]? <input type="checkbox"/> Yes <input type="checkbox"/> No					
For moderately to severely active Crohn's disease, also answer the following: Does the patient have history of failure, contraindication, or intolerance to at least one tumor necrosis factor (TNF) blocker [e.g., Remicade/Infliximab, Humira (adalimumab), Cimzia (certolizumab pegol)]? <input type="checkbox"/> Yes <input type="checkbox"/> No Does the patient have history of failure, contraindication, or intolerance to treatment with at least one immunomodulator or corticosteroids [e.g., Purinethol (6-mercaptopurine), Imuran (azathioprine), Sandimmune (cyclosporine A), Prograf (tacrolimus), MTX (methotrexate)]? <input type="checkbox"/> Yes <input type="checkbox"/> No Is this for continuation of prior Stelara therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No					
For intravenous (IV) Stelara, answer the following: Is Stelara to be administered as an intravenous induction dose? <input type="checkbox"/> Yes <input type="checkbox"/> 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: <input type="checkbox"/> 260 mg for patients weighing 55 kg or less <input type="checkbox"/> 390 mg for patients weighing more than 55 kg to 85 kg <input type="checkbox"/> 520 mg for patients weighing more than 85 kg					

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1230 US Highway 11
Gouverneur, NY 13642
Phone: 1-877-635-9545

Prior Authorization Fax: 1-844-712-8129



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Reauthorization:

If this is a reauthorization request, answer the following questions:

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.

Please fax this form to 1-844-712-8129 to initiate a prior authorization review for the member and medication above.

Please note: plan benefits may limit or exclude coverage of specific medications including those requested on this form.

I certify, to the best of my knowledge, the statements and information provided on this form are factual and correct.

Provider/Representative (and Title): _____ Date: _____

PROACT INTERNAL USE ONLY:

Clinical Review Decision

Approved, through

Denied (documentation attached, if necessary)

Tracking:

1st Attempt

2nd Attempt

Letter Mailed: