PARAMOUNT
Affiliate of ProMedica

Criteria: P0181
Approved: 11/2014
Verified: 9/2019
Reviewed:

Prior Authorization Criteria Form

This form applies to Paramount Commercial Members Only

Stelara

Complete/review information, sign and date. Please fax signed forms to Paramount at **1-844-256-2025**. You may contact Paramount by phone at **1-419-887-2520** with questions regarding the Prior Authorization process. When conditions are met, we will authorize the coverage of Stelara.

Drug Name (select from list of drugs shown)

Other, Please specify Stelara (ustekinumab)

Quantity _____ **Frequency** _____ **Strength** _____

Route of Administration _____ **Expected Length of Therapy** _____

Patient Information

Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone:

Prescribing Physician

Physician Name: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please circle the appropriate answer for each question.

1. Has the patient previously received Stelara for plaque psoriasis? Y N
   [If yes, skip to question 3.]
2. Has documentation to support continued clinical effectivenessbeen submitted with the renewal request? Y N
   [If yes, skip to question 12.]
   [If no, no further questions.]
3. Has the patient previously received Stelara for psoriatic arthritis or Crohn s disease? Y N
   [If yes, skip to question 5.]
4. Has documentation to support continued clinical effectiveness been submitted with the renewal request? Y N
   [If yes, skip to question 11.]
   [If no, no further questions.]
5. Is Stelara requested for a patient with moderate to severe plaque psoriasis? Y N
   [If no, skip to question 8.]

6. Does the patient meet one of the following criteria: A) At least 5 percent of the body surface area was affected by plaque psoriasis at the time of diagnosis, or B) Crucial body areas (e.g., feet, hands, face, neck, groin, intertriginous areas) were affected by plaque psoriasis at the time of diagnosis? [If no, no further questions.] Y N

7. Does the patient have an inadequate response, intolerance or contraindication to BOTH of the following: A) a three to four month trial of phototherapy, B) a three to four month trial of pharmacologic treatment with methotrexate, cyclosporine, or acitretin? Action Required: If Yes , attach office notes and clinical documentation for the response given. Y N

[If yes, skip to question 12.]
[If no, no further questions.]

8. Is Stelara prescribed for a patient with active psoriatic arthritis? Y N

[If yes, skip to question 11.]

9. Is Stelara prescribed for a patient with moderately to severely active Crohn s disease? Y N

[If no, no further questions.]

10. Did the patient have an inadequate response, intolerance, or contraindication to at least one conventional therapy option for Crohn s disease (e.g., corticosteroids, sulfasalazine, azathioprine, mesalamine), or to a tumor necrosis factor (TNF)-inhibitor for Crohn s disease? Y N

[If no, no further questions.]

11. Is the patient 18 years of age or older? Y N

[No further questions.]

12. Is the patient 12 years of age or older? Y N

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature and Date