Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
Stelara (ustekinumab) Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk
Length of Authorizations: Initial- 6 months; Continuation- 12 months

Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **Stelara (ustekinumab).** Please complete and fax this form back to Kaiser Permanente within 24 hours [fax: 1-866-331-2104]. If you have any questions or concerns, please call 1-866-331-2103. **Requests will not be considered unless this form is complete.**

KP-MAS Formulary can be found at: Pharmacy | Community Provider Portal | Kaiser Permanente

1 – Patient Information

Patient Name: _____ Kaiser Medical ID#: _____ Date of Birth: _____

2 – Prescriber Information

Is the prescriber a Rheumatologist, Gastroenterologist or Dermatologist? □ No □ Yes

If consulted with a specialist, specialist name and specialty: _____

Prescriber Name: _____ Specialty: _____ NPI: _____

Prescriber Address: _____

Prescriber Phone #: _____Prescriber Fax #: _____

3 – Pharmacy Information

Pharmacy Name: _____ Pharmacy NPI: _____

Pharmacy Phone #_____ Pharmacy Fax #: _____

4 – Drug Therapy Requested

Drug 1: Name/Strength/Formulation: _____
Sig: _____

Drug 2: Name/Strength/Formulation: _____
Sig: _____

5– Diagnosis/Clinical Criteria

1. Is this request for initial or continuing therapy?

□ Initial therapy □ Continuing therapy, state start date: _____

2. Indicate the patient's diagnosis for the requested medication: _____

Clinical Criteria:

Rheumatology:

1. Member has a diagnosis of active psoriatic arthritis
   □ No □ Yes

2. **AND** member has documented inadequate response (of at least a 3-month trial), intolerance, or contraindication to BOTH of the following:
   a. ONE or more tumor necrosis factor (TNF alpha) inhibitors: Inflectra or Remicade (infliximab), Enbrel (etanercept), adalimumab biosimilars (Amjevita preferred) or Humira
   b. **AND** Cosentyx (secukinumab)
   □ No □ Yes

Dermatology:

1. Member has diagnosis of moderate-to-severe plaque psoriasis
   □ No □ Yes

2. **AND** meets criteria for Cosentyx
   □ No □ Yes

3. **AND** documented inadequate response (of at least 3 month trial), intolerance, or contraindication to Cosentyx (secukinumab) AND at least 1 TNF inhibitor (e.g. adalimumab biosimilars (Amjevita preferred) or Humira, Enbrel, Inflectra)
   □ No □ Yes

4. **AND** documented inadequate response, intolerance, or contraindication to Tremfya OR Skyrizi
   □ No □ Yes

Gastroenterology:

1. Member has diagnosis of moderately to severely active Crohn's disease,
   □ No □ Yes

2. **AND** inadequate response, contraindication or inability to tolerate ONE conventional therapy (i.e., azathioprine or 6-mercaptopurine),
   □ No □ Yes

3. **AND** inadequate response, contraindication or an inability to tolerate corticosteroids (i.e., prednisone, methylprednisolone, budesonide),
   □ No □ Yes

4. **AND** documented inadequate response (of at least a 3-month trial), intolerance, or contraindication to the following:
   a. Inflectra or Remicade (infliximab),
   b. **AND** adalimumab biosimilars (Amjevita preferred) or Humira OR Entyvio (vedolizumab),
   □ No □ Yes

5. **AND** patient has documented negative test for tuberculosis within the past 12 months
   □ No □ Yes

OR

1. Member has documented moderately to severely active Ulcerative Colitis,
   □ No □ Yes

2. **AND** inadequate response, contraindication or inability to tolerate ONE conventional therapy (i.e., mesalamine, azathioprine or 6-mercaptopurine),
   □ No □ Yes

3. **AND** inadequate response, contraindication or an inability to tolerate corticosteroids (i.e., prednisone),
   □ No □ Yes

4. **AND** documented inadequate response (of at least a 3-month trial), intolerance, or contraindication to the following:
   a. Inflectra or Remicade (infliximab),
   b. **AND** adalimumab biosimilars (Amjevita preferred) or Humira OR Entyvio (vedolizumab) OR Xeljanz (tofacitinib),

   □ No □ Yes

5. **AND** patient has documented negative test for tuberculosis within the past 12 months?
   □ No □ Yes

For continuation of therapy, please respond to <u>additional questions</u> below:

1. Member has had positive clinical response to medication
   □ No □ Yes

2. **AND** specialist follow-up occurred in the last 12 months since last review
   □ No □ Yes

7 – Prescriber Sign-Off

Additional Information –

1. **Please submit chart notes/medical records for the patient that are applicable to this request.**
2. **If member has not tried preferred agent(s) please provide rationale/explanation and any additional supporting information that should be taken into consideration for the requested medication:**

_____

_____

_____

I certify that the information provided is accurate. Supporting documentation is available for State audits.

Prescriber Signature:	**Date:**