



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](tel:1-866-331-2104)]. If you have any questions or concerns, please call [1-866-331-2103](tel: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 additional questions 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: |
|------------------------------|--------------|

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