**Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.**
**Stelera (ustekinumab) Prior Authorization (PA)**
**Pharmacy Benefits Prior Authorization Help Desk**
**Length of Authorization: 12 months**

**Instructions:**

This form is used by Kaiser Permanente and/or participating providers for coverage of **Stelera (ustekinumab) .** Please complete all sections, incomplete forms will delay processing. 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. The KP-MAS Formulary can be found at:**
**http://pithelp.appl.kp.org/MAS/formulary.html**

## 1 – Patient Information

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

## 2 – Provider Information

Provider Name: _____ Specialty: _____ Provider NPI: _____

Provider Address: _____

Provider Phone #: _____Provider Fax #: _____

Please check the boxes that apply:
□ Initial Request □ Continuation of Therapy Request

## 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. Does the member have diagnosis of one of the following? **AND**
   □ Adult Crohn's disease (CD)

   □ Psoriatic arthritis (PsA)

   □ Ulcerative Colitis (UC)

   □ Plaque Psoriasis (PsO)

   □ Other: _____
2. Was there therapeutic failure on oral methotrexate? **AND**
   □ No □ Yes

3. Was there therapeutic failure to one of the preferred agents? (e.g. Enbrel, Humira)
   □ No □ Yes

4. If the indication is for Plaque Psoriasis moderate to severe, is the patient's age ≥ 6 years?
   □ No □ Yes

## 6 – Provider Sign-Off

**Additional Information – Please provide any additional information that should be taken into consideration.**

_____

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

| **Provider Signature:** | **Date:** |
|---|---|
| | |