AmeriHealth Caritas North Carolina

Pharmacy Request for Prior Approval – Stelara Injection

Beneficiary Information

1. Beneficiary Last Name: _____ 2. First Name: _____
3. Beneficiary ID #: _____ 4. Beneficiary Date of Birth: _____ 5. Beneficiary Gender: _____

Prescriber Information

6. Prescriber Name: _____ NPI #: _____
Mailing address: _____ City: _____ State: _____ ZIP: _____
7. Requester Contact Information: _____
Name: _____ Phone #: _____ Fax #: _____

Drug Information

8. Drug Name: _____ 9. Dose: _____ 10. Directions: _____
11. Length of Therapy: __up to 30 days __60 days __90 days __120 days __180 days __365 days __Other: _____

Clinical Information

Request for Crohn's Disease (Adult):

1. Does the beneficiary have a diagnosis of moderate to severe Crohn's Disease? Yes___ No___
2. Is the beneficiary 18 years of age or older? Yes___ No___
3. Is the beneficiary on another injectable biologic immunomodulator? Yes___ No___
4. Has the beneficiary been considered and screened for the presence of latent tuberculosis infection? Yes___ No___
5. Has the beneficiary been tested with Hep B SAG and Core Ab? Yes___ No___
6. Has the beneficiary had a trial and failure of Humira, or a clinical reason beneficiary cannot try Humira? Yes___ No___

Request for Plaque Psoriasis (Adult):

1. Does the beneficiary have a documented definitive diagnosis of moderate-to-severe Chronic Plaque Psoriasis? Yes___ No___
2. Is the beneficiary 18 years of age or older? Yes___ No___
3. Is the beneficiary on another injectable biologic immunomodulator? Yes___ No___
4. Has the beneficiary been considered and screened for the presence of latent tuberculosis infection? Yes___ No___
5. Has the beneficiary been tested with Hep B SAG and Core Ab? Yes___ No___
6. Does the beneficiary have a body surface area (BSA) involvement of at least 3%? Yes___ No___
7. Does the beneficiary have involvement of the palms, soles, head and neck, or genitalia, causing disruption in normal daily activities and/or employment? Yes___ No___
8. Has the beneficiary failed to respond to, or has been unable to tolerate phototherapy and **ONE** of the following medications, or beneficiary has contraindications to these treatments: Soriatane (acitretin), Methotrexate, and/or Cyclosporine? Yes___ No___
9. Has the beneficiary had a trial and failure of Cosentyx, Enbrel or Humira or a clinical reason beneficiary cannot try Cosentyx, Enbrel or Humira? Yes___ No___

Request for Plaque Psoriasis (Pediatric): (Ages 6 & up)

1. Does the beneficiary have a diagnosis of plaque psoriasis and is a candidate for systemic therapy or phototherapy? Yes___ No___
2. Is the beneficiary on another injectable biologic immunomodulator? Yes___ No___
3. Has the beneficiary been considered and screened for the presence of latent tuberculosis infection? Yes___ No___
4. Has the beneficiary been tested with Hep B SAG and Core Ab? Yes___ No___
5. Has the beneficiary experienced a therapeutic failure/inadequate response with or has a contraindication or intolerance to methotrexate? Yes___ No___
6. Does the beneficiary have a body surface area (BSA) involvement of at least 3%? Yes___ No___
7. Does the beneficiary have involvement of the palms, soles, head and neck, or genitalia, causing disruption in normal daily activities and/or employment? Yes___ No___
8. Has the beneficiary had a trial and failure of Cosentyx or Enbrel or a clinical reason beneficiary cannot try Cosentyx or Enbrel? Yes___ No___

Request for Psoriatic Arthritis:

1. Does the beneficiary have a documented definitive diagnosis of Psoriatic Arthritis? Yes___ No___
2. Is the beneficiary 6 years of age or older? Yes___ No___
3. Is the beneficiary on another injectable biologic immunomodulator? Yes___ No___
4. Has the beneficiary been considered and screened for the presence of latent tuberculosis infection? Yes___ No___
5. Has the beneficiary been tested with Hep B SAG and Core Ab? Yes___ No___
6. Does the beneficiary have a documented inadequate response or inability to take methotrexate? Yes___ No___

Fax this form to: 1-877-234-4274, or call Pharmacy Prior Authorization: 1-866-885-1406

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7. For beneficiaries 18 years of age or older: Has the beneficiary had a trial and failure of Cosentyx, Enbrel or Humira or a clinical reason beneficiary cannot try Cosentyx, Enbrel or Humira? Yes___ No___
8. For beneficiaries 6 years of age to 17 years of age: Has the beneficiary had a trial and failure of Cosentyx, or a clinical reason beneficiary cannot try Cosentyx? Yes___ No___

Request for Ulcerative Colitis (Adult):

1. Does the beneficiary have a diagnosis of ulcerative colitis? Yes___ No___
2. Is the beneficiary 18 years of age or older? Yes___ No___
3. Is the beneficiary on another injectable biologic immunomodulator? Yes___ No___
4. Has the beneficiary been considered and screened for the presence of latent tuberculosis infection? Yes___ No___
5. Has the beneficiary been tested with Hep B SAG and Core Ab? Yes___ No___
6. Has the beneficiary had a trial and failure of Humira, or a clinical reason beneficiary cannot try Humira? Yes___ No___

Request for FDA Approved Diagnosis Not Listed Above:

1. Diagnosis: _____
2. Is the beneficiary on another injectable biologic immunomodulator? Yes___ No___
3. Has the beneficiary been considered and screened for the presence of latent tuberculosis infection? Yes___ No___
4. Has the beneficiary been tested with Hep B SAG and Core Ab? Yes___ No___

Signature of Prescriber: _____ Date: _____

***Prescriber signature mandatory**

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

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