

Stelara

Prior Authorization Form

IF THIS IS AN URGENT REQUEST, Please Call UPMC Health Plan Pharmacy Services.

Otherwise please return completed form to:

UPMC HEALTH PLAN PHARMACY SERVICES

PHONE 800-979-UPMC (8762)

FAX 412-454-7722

PLEASE TYPE OR PRINT NEATLY

Please complete all sections of this form. Incomplete responses may delay this request.

Office Contact:		Provider Specialty:		
Provider First Name:		Provider Last Name:		
Provider Phone:		Provider Fax:	Provider NPI #:	
Patient Name:		Patient UPMC Health Plan ID Number:	Patient DOB:	
Drug Requested:	Strength:	Frequency:	Qty Dispensed:	Patient Age:
<i>Generic equivalent drugs will be substituted for Brand name drugs unless you specifically indicate otherwise.</i>				
<input type="checkbox"/> New medication	If ongoing, provide date started:	If medication is ongoing, Did the member show improvement while on therapy?	<input type="checkbox"/> Yes	
<input type="checkbox"/> Ongoing medication			<input type="checkbox"/> No	
Diagnosis:		Date of diagnosis:		

Medical History

Please specify member's weight:				
Please indicate plaque psoriasis disease severity:		<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
Is there evidence of Infection?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Date of PPD (tuberculin) test:		Result of PPD test: <input type="checkbox"/> Positive <input type="checkbox"/> Negative		
Is the member currently using another TNF-blocking agent or biologic agent in combination with Stelara?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, please indicate drug name:				
Please indicate % of Body Surface Area (BSA) involvement:		<input type="checkbox"/> Less than 10 %	<input type="checkbox"/> Greater than or equal to 10%	
Does the member have plaque psoriasis on the palms, soles, head, neck, or genitalia?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has the member tried and failed topical treatments? If yes, please specify drug name(s):			<input type="checkbox"/> Yes	<input type="checkbox"/> No
Reason for discontinuation:				
Has the member tried and failed phototherapy or photochemotherapy?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
Please indicate if the member tried and failed any of the following for at least 3 months?				
<input type="checkbox"/> Methotrexate		<input type="checkbox"/> Cyclosporine (Neoral, Sandimmune)	<input type="checkbox"/> Acitretin (Soriatane)	
Please provide dates of therapy and dose:				
Reason for discontinuation:				

Please provide any additional information which should be considered in the space below:
