UPMC Health Plan

STELARA MEDICAL POLICY

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: 1-800-979-UPMC (8762) FAX: 412-454-7722

PLEASE TYPE OR PRINT NEATLY
Incomplete responses may delay this request.

Office contact:		**Provider specialty:**	
Provider first name		**Provider last name:**	
Provider phone #:		**Provider fax #:**	
Patient name:	**Patient UPMC Health Plan Member ID #:**	**Patient DOB:**	**Patient age:**
Drug requested: ☐ **Brand** ☐ **Generic**	**Strength:**	**Frequency:**	**Quantity dispensed (including units):**

Generic equivalent drugs will be substituted for brand name drugs unless you specifically indicate otherwise.

☐ **New medication** ☐ **Ongoing medication**	**If ongoing, please provide start date:**	**If ongoing, did the member show improvement while on therapy?**	☐ **Yes** ☐ **No**
Diagnosis:		**Date of diagnosis:**	
Please indicate place of administration	☐ Physician office ☐ Hospital/Clinic ☐ Patient home	**Will the medication be (select one):** ☐ Billed directly by the provider via JCODE JCODE: _____ ☐ Billed by a pharmacy and delivered to the provider ☐ Billed by a pharmacy and delivered to the patient	
Please provide hospital/facility name and address:			

Please complete the following for all diagnoses:

Will this medication be administered in a physician office by a healthcare professional? ☐ Yes ☐ No

Authorization will be approved for a Stelara request only when administrated by healthcare professionals.* *(Does not apply to Medicare.)***

Please specify the member's weight (indicating units):

Please indicate disease severity ☐ Moderate ☐ Severe

Date of most recent tuberculosis skin test: _____ Result of tuberculosis skin test: ☐ Positive ☐ Negative

Does the member currently have evidence of infection? ☐ Yes ☐ No

Is the member currently using another TNF-blocking or biologic agent in combination with Stelara? ☐ Yes ☐ No
If yes, please provide name of medication: _____

Please indicate the diagnosis on the left and complete the corresponding questions.

☐ Plaque Psoriasis

Please indicate % of Body Surface Area involvement: ☐ Less than 5% ☐ Greater than or equal to 5%

Does the member have plaque psoriasis on the palms, soles, head, neck, or genitalia? ☐ Yes ☐ No

Has the member tried and failed topical treatments? ☐ Yes ☐ No
If yes, please specify drug name(s): _____
Reason(s) for discontinuation: _____

Has the member tried and failed phototherapy or photochemotherapy? ☐ Yes ☐ No

Please indicate if the member tried and failed any of the following for at least 3 months:
☐ Methotrexate ☐ Cyclosporine (Neoral, Sandimmune) ☐ Acitretin (Soriatane)
Please provide dates of therapy and dose: _____
_____
Reason for discontinuation: _____

Please be sure to complete and include the 2nd page of this form.

**** Enbrel and Humira are the preferred TNF products for the UPMC Health Plan.**

STELARA

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Patient Name	**Patient UPMC Health Plan ID Number:**	**Patient DOB:**

Please be sure to complete and include the 1st page of this form.

Please indicate the diagnosis on the left and complete the corresponding questions.

☐ Psoriatic Arthritis	Is the member's disease currently active? ☐ Yes ☐ No Has the member tried and failed any non-steroidal anti-inflammatory drugs (NSAIDs)? ☐ Yes ☐ No If yes, please specify drug name(s): _____ Reason(s) for discontinuation: _____ Please indicate if the member tried and failed any of the following for at least 3 months: ☐ Methotrexate ☐ Cyclosporine (Neoral, Sandimmune) ☐ Sulfasalazine (Azulfidine) ☐ Leflunomide (Arava) Please provide dates of therapy and dose: _____ _____ Reason for discontinuation: _____

Please provide any additional information in the space below.