AmeriHealth Administrators

Today's date:_____

Intended date of injection: _____

# Prior Authorization Form – Stelara®

## Buy-and-bill requests for this drug should be submitted through NaviNet®.

**ONLY COMPLETED REQUESTS WILL BE REVIEWED.**

**Check one:** ☐ New start ☐ Continued treatment

| Patient information (please print) | | Physician information (please print) | |
|---|---|---|---|
| Patient name | | Prescribing physician | |
| Address | | Office address | |
| City, state, ZIP | | City, state, ZIP | |
| Patient telephone # | | Office contact | |
| Patient ID | | Office telephone # | |
| Date of birth | Weight | Fax # | NPI |

**This drug will be delivered to the requesting physician for the formulation selected below:**
**Prefilled syringe:** _____ 45mg _____ 90mg or **Vial:** _____ 45mg _____ 130mg

**** A copy of the prescription must accompany the medication request for delivery.****

**1) Diagnosis for drug requested (must include ICD-10):** _____

**2) Patient medical information**

***For Crohn's disease only***

a. Does the patient have a documented history of failure, contraindication, or intolerance to at least one of the following? Check all that apply and list the drug(s) on the line provided below: ☐ Yes ☐ No
- ☐ Immunomodulators (e.g., azathioprine, 6-mercaptopurine, methotrexate); _____
- ☐ Corticosteroids (e.g., budesonide [Entocort® EC], prednisone, hydrocortisone, methylprednisolone); _____
- ☐ Anti-tumor necrosis factor agents (e.g., certolizumab pegol [Cimzia®], adalimumab [Humira®]); _____

b. Had/Will the patient receive one intravenous infusion before switching to subcutaneous injections? ☐ Yes ☐ No

***For plaque psoriasis only***

a. Is the patient's chronic plaque psoriasis classified as moderate-to-severe? ☐ Yes ☐ No

b. Does the patient have a documented history of failure, contraindication, or intolerance to any of the following? ☐ Yes ☐ No
Check all that apply and list the drug(s) on the line provided below:
- ☐ Topical steroids available by prescription only; _____
- ☐ Topical nonsteroids available by prescription only (e.g., topical calcipotriene [Dovonex®], topical anthralin, topical retinoids [Tazorac®]); _____
- ☐ Topical immunomodulators (e.g., pimecrolimus [Elidel®], tacrolimus [Protopic®]); _____
- ☐ Methotrexate; _____
- ☐ Oral retinoids (e.g., Soriatane®); _____
- ☐ Cyclosporine (e.g., Neoral, Gengraf); _____

***For psoriatic arthritis only***

a. Does the patient have a documented history of failure, contraindication, or intolerance to any disease-modifying antirheumatic drug (DMARD) such as, but not limited to, sulfasalazine, azathioprine, hydroxychloroquine, cyclosporine, methotrexate, or anti-tumor necrosis factor agents? ☐ Yes ☐ No
If yes, list drug(s): _____

**3) Prescription information**

Quantity _____ refill x _____ month(s)

Instructions (include dose) _____ every _____ day(s)/ week(s)/ month(s)

Physician's signature _____

**Please fax this completed form to 215-761-9580.**

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