Capital BLUE

# Ustekinumab (Stelara) MP-2.140

**Preauthorization Request**

**Preauthorization is not a guarantee of payment)**

## SECTION I – General Information

| | |
|---|---|
| Initial start date of therapy: / /<br>Anticipated date of next infusion: / / | Fax completed form to: **1-866-805-4150 toll free** |

## SECTION II – Member Information

| | | |
|---|---|---|
| Member Name: | Member ID: | Member DOB: / / |

Plan Type: ☐ Traditional ☐ Comprehensive ☐ PPO ☐ POS ☐ KHPC ☐ Special Care ☐ Sr. Blue HMO ☐ Sr. Blue PPO

## SECTION III – Provider Information Required

| | |
|---|---|
| **Requesting Provider Name**:<br>**Address**: | **Requesting Provider CBC #**_____<br>**NPI #** _____ |
| Telephone #: | Fax #: |
| Office Contact Name: | Office Contact Telephone #: |

Place of Service: ☐ MD Office ☐ Name/Address of the Hospital/Clinic/Home Health

## SECTION IV – Preauthorization Requirements and Clinical Criteria

**Diagnosis:** ☐ Moderate to severe chronic plaque psoriasis ☐ Active psoriatic arthritis (PsA), alone
☐ Active psoriatic arthritis (PsA), in combination with methotrexate.

ICD Code: _____ HCPC: J3357

Prescribed in consultation with a rheumatologist or dermatologist? ☐ Yes ☐ No

☐ **Initial Authorization** Request (maximum 12 weeks). To be completed for initial authorization only.

**Has the patient been tested for latent tuberculosis?:** ☐ Yes ☐ No Results:_____

Has the patient tried and failed non-biologic DMARD therapy (e.g., Methotrexate, Azathioprine, Cyclosporine).
☐ Yes ☐ No

Note: If yes, please list any previous medications that were tried and failed. Include reason for discontinuation (intolerance, hypersensitivity, inadequate response etc). Please attach clinic notes.

1. Name of drug: Trial Dates: / / through / /
   Reason for discontinuation
2. Name of drug Trial Dates: / / through / /
   Reason for discontinuation

Has the patient tried and failed to respond to phototherapy (e.g., ultraviolet B [UVB] or oral methoxsalen plus UVA light [PUVA])? ☐ Yes ☐ No
If yes, Trial Dates: / / through / /

☐ **Re-Authorization (Maintenance Therapy)** maximum 12 months: To be completed for continuation of therapy

**Has the patient been tested for latent tuberculosis?:** ☐ Yes ☐ No Results:_____

Has the patient demonstrated improvement as measured by a standardized disease activity tool (e.g., Simplified Psoriasis Area Severity Index [SPASI], Psoriasis Areas Severity Index [PASI]). Yes ☐ No ☐

**Dosing Information:**

Dose: Frequency:

## SECTION V – Required Physician Signature

| | |
|---|---|
| **Physician's Signature** | Date: / / |



**6/4/13; 3/26/14 Updated**