Today's date:_______________________________________ **Date medication needed:** ___________________________

Prior Authorization Form - Stelara

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

☐ **No delivery requested; physician will use office supply. Authorization only.**

☐ **Delivery requested to the physician's office.**

**** 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 plaque psoriasis only:

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

b. Does the patient have a current infection? ☐ Yes ☐ No

c. Is at least 5% of the patient's body surface area involved (<5% for sensitive areas)? ☐ Yes ☐ No
If yes, list affected areas:____

d. Does the patient have a documented history of failure, contraindication, or intolerance to at least a 3-month trial with at least two of the following? (check all that apply): ☐ Yes ☐ No

- ☐ Topical steroids available by prescription only;
  (list drug[s]) ____
- ☐ Topical nonsteroids available by prescription only;
  (list drug[s]) ____
- ☐ Methotrexate;
- ☐ Retinoids (e.g., Soriatane);
  (list drug[s]) ____
- ☐ Cyclosporine (e.g., Neoral, Gengraf);
  (list drug[s]) ____

For psoriatic arthritis only:

a. Does the patient have a documented history of failure, contraindication, or intolerance to at least a 3-month trial of 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.