Montana Healthcare Programs Prior Authorization Request Form for Use of Stelara® (ustekinumab)

Member name:  DOB:  Date:  

Member ID:  Prescriber phone:  

Prescriber name and specialty if applicable:  Prescriber fax:  

Dosage requested:  

Please complete below information for applicable situation, Initiation or Continuation of therapy:

☐ INITIATION OF THERAPY

Please check appropriate diagnosis and complete corresponding information:

1. Moderate to Severe Plaque Psoriasis or Active Psoriatic Arthritis
   a. Member is 6 years of age or older: ☐ Yes ☐ No

   b. Member has a diagnosis of:
      ☐ Moderate to Severe Plaque Psoriasis
      ☐ Psoriatic Arthritis

   c. Medication is prescribed by, or in consultation with a: ☐ Dermatologist ☐ Rheumatologist

      Action Required: If not written by a specialist, a copy of the annual specialty consult is required (please attach copy of consult).

      Name of specialist: ___________________________ Contact date: ________________

   d. Member has trialed, and had an inadequate response or contraindication to a Montana Healthcare Programs preferred drug with the same indication: ☐ Yes ☐ No

      Drug name: ___________________________ Dates of use: __________________________

   e. Provider attests to the following:
      ☐ The member has been screened for TB prior to initiating treatment
      ☐ The provider will monitor for active infection, malignancies, Posterior Reversible Encephalopathy Syndrome (PRES) and noninfectious pneumonia

   f. Provider attests that member will not use Stelara® concomitantly with other biologics: ☐ Yes ☐ No
LIMITATIONS:

- **Moderate to Severe Plaque Psoriasis:**
  Adults with psoriasis the subcutaneous dose is weight based:
  - ≤ 100 kg = 45 mg initially and 4 weeks later, then every 12 weeks
  - > 100 kg = 90 mg initially and 4 weeks later, then every 12 weeks

  Pediatric patients aged 6 to 17 years, with psoriasis, the subcutaneous dose is weight based:
  - < 60 kg = 0.75 mg/kg at week 0 and 4, then every 12 weeks
  - 60 – 100 kg = 45 mg at week 0 and 4, then every 12 weeks
  - > 100 kg = 90 mg at week 0 and 4, then every 12 weeks

- **Active Psoriatic Arthritis:**
  Adults with psoriatic arthritis the subcutaneous dose is weight based:
  - ≤ 100 kg = 45 mg initially and 4 weeks later, followed by 45 mg every 12 weeks
  - > 100 kg = 90 mg initially and 4 weeks later, followed by 90 mg every 12 weeks

  Pediatric patients, aged 6 to 17 years, with psoriatic arthritis the subcutaneous dose is weight based:
  - < 60 kg = 0.75 mg/kg at week 0 and 4, then every 12 weeks
  - 60 – 100 kg = 45 mg at week 0 and 4, then every 12 weeks
  - > 100 kg with co-existent moderate to severe plaque psoriasis = 90 mg at week 0 and 4, then every 12 weeks

  **Initial authorization will be issued for three doses (weeks zero, four and 16).**

2. **Moderately to Severely Active Ulcerative Colitis or Moderately to Severely Active Crohn’s Disease**
   a. Member is 18 years of age or older: ☐ Yes ☐ No

   b. Member has a diagnosis of:
      ☐ Moderately to severely active Ulcerative Colitis
      ☐ Moderately to severely active Crohn’s Disease

   c. Medication is prescribed by, or in consultation with: ☐ Gastroenterologist

      **Action Required:** If not written by a specialist, a copy of the annual specialty consult is required (please attach copy of consult).

      Name of specialist: ________________________________ Contact date: ________________

   d. Member has trialed, and had an inadequate response or contraindication to a Montana Healthcare Programs preferred drug with the same indication: ☐ Yes ☐ No

      Drug name: ___________________________ Dates of use: _____________________________
c. Provider attests to the following:
   - The member has been screened for tuberculosis (TB) prior to initiating treatment
   - The provider will monitor for active infection, malignancies, Posterior Reversible Encephalopathy Syndrome (PRES) and noninfectious pneumonia

f. Provider attests that member will **not** use Stelara® concomitantly with other biologics: □ Yes □ No

**LIMITATIONS:**

- **Moderately to Severely Active Ulcerative Colitis**
  Initial intravenous infusion of Stelara® is weight based:
  - Up to 55 kg = 260 mg
  - > 55 kg to 85 kg = 390 mg
  - > 85 kg = 520 mg
  Maintenance subcutaneous injection:
    - 90 mg at week 8, then every 8 weeks thereafter

- **Moderately to Severely Active Crohn’s Disease**
  Initial intravenous infusion of Stelara® is weight based:
  - Up to 55 kg = 260 mg
  - > 55 kg to 85 kg = 390 mg
  - > 85 kg = 520 mg
  Maintenance subcutaneous injection:
    - 90 mg at week 8, then every 8 weeks thereafter

*Initial authorization will be issued for two doses (infusion at week zero and injection at week eight).*

□ **CONTINUATION OF THERAPY**

1. Member has been adherent to Stelara®: □ Yes □ No

2. Member has documentation of a positive clinical response to Stelara® therapy (e.g., reduction in the frequency and/or severity of symptoms and exacerbations). □ Yes □ No

3. Annual specialist consult attached if prescriber is not a specialist: □ Yes □ No □ N/A - prescriber is a specialist

4. Provider attests that member will **not** use Stelara® concomitantly with other biologics: □ Yes □ No

*Reauthorization will be issued for 1 year.*

Please complete form, including required attachments and fax to
Drug Prior Authorization Unit at 1-800-294-1350