PRIORITY PARTNERS
7231 Parkway Dr., Suite 100
Hanover, MD 21076

JOHNS HOPKINS
HEALTH PLANS

9/16/2025

Prior Authorization

Internal Use Only

JOHNS HOPKINS HEALTH PLANS

Selarsdi and Yesintek - Priority Partners MCO

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Johns Hopkins Health Plans at **1-410-424-4607**.
Please contact Johns Hopkins Health Plans at **1-888-819-1043** with questions regarding the Prior Authorization process.
When conditions are met, we will authorize the coverage of Selarsdi and Yesintek - Priority Partners MCO.

Drug Name (select from list of drugs shown)

Selarsdi IV (ustekinumab-aekn) Selarsdi SC (ustekinumab-aekn) Yesintek IV (ustekinumab-kfce)
Yesintek SC (ustekinumab-kfce)

Quantity Frequency Strength

Route of Administration Expected Length of Therapy

Patient Information
Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone:

Prescribing Physician
Physician Name: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please circle the appropriate answer for each question.

1. Has the plan authorized this medication in the past for this patient (i.e., previous authorization is on file under this plan)? Y N

	NOTE: The use of physician samples, or manufacturer product discounts, does not guarantee coverage under the provisions of the medical and/or pharmacy benefit. All pertinent criteria must be met in order to be eligible for benefit coverage.	
	[If yes, skip to question 20.]	
2.	Does the patient have any of the following diagnoses: A) sarcoidosis, B) graft-versus-host disease, C) interleukin-2 toxicity, D) Langerhans cell histiocytosis, E) myositis, F) nephrotic syndrome, G) amyloidosis, H) periodic fever syndrome, I) renal transplant syndrome, J) moderate to severe Crohn's disease in pediatric patient (as first line therapy), K) definitive radiographic axial spondyloarthritis with evidence of structural damage on sacroiliac joints?	Y N
	[If yes, no further questions.]	
3.	Has the patient previously received biologic therapy?	Y N
	[If yes, skip to question 6.]	
4.	Has the patient undergone tuberculosis screening within the past year?	Y N
	NOTE: Submission of medical records is required.	
	[If no, no further questions.]	
5.	Does the patient have an active tuberculosis infection prior to starting the requested biologic therapy?	Y N
	NOTE: Submission of medical records is required.	
	[If yes, no further questions.]	
6.	Does the patient have a diagnosis of active psoriatic arthritis?	Y N
	NOTE: Submission of medical records is required.	
	[If no, skip to question 9.]	
7.	Has the patient tried and had insufficient response to at least two disease-modifying antirheumatic drugs (DMARDs) including methotrexate?	Y N
	NOTE: Submission of medical records is required.	
	[If yes, skip to question 19.]	
8.	Does the patient have a contraindication to at least two disease-modifying antirheumatic drugs (DMARDs) including methotrexate?	Y N
	NOTE: Submission of medical records is required.	
	[If yes, skip to question 19.]	
	[If no, no further questions.]	
9.	Does the patient have a diagnosis of chronic moderate to severe plaque psoriasis?	Y N
	NOTE: Submission of medical records is required.	
	[If no, skip to question 14.]	
10.	Does the patient have either of the following: A) body surface area involvement of greater than 10 percent, or B)	Y N

body surface area involvement of less than or equal to 10 percent, but involves sensitive areas (palms/soles of feet, genitalia and head/neck)?		
NOTE: Submission of medical records is required.		
[If no, no further questions.]		
11. Has the patient tried and had insufficient response or contraindication to at least one of the following: A) phototherapy, or B) systemic therapy with methotrexate or cyclosporine?	Y N	
NOTE: Submission of medical records is required.		
[If no, no further questions.]		
12. Does the patient have moderate disease?	Y N	
[If no, skip to question 19.]		
13. Has the patient had a documented trial and insufficient response to topical pharmacologic therapy (corticosteroids, vitamin D analogues, or retinoids), unless their use is contraindicated?	Y N	
NOTE: Submission of medical records is required.		
[If yes, skip to question 19.]		
[If no, no further questions.]		
14. Does the patient have a diagnosis of moderately to severely active Crohn's disease?	Y N	
NOTE: Submission of medical records is required.		
[If no, skip to question 16.]		
15. Has the patient tried and had insufficient response with conventional therapies such as corticosteroids, or immunomodulators such as azathioprine, 6-mercaptopurine, or methotrexate?	Y N	
NOTE: Submission of medical records is required.		
[If yes, skip to question 18.]		
[If no, no further questions.]		
16. Does the patient have a diagnosis of moderate to severe ulcerative colitis?	Y N	
NOTE: Submission of medical records is required.		
[If no, no further questions.]		
17. Has the patient tried and had insufficient response to immunosuppressants such as corticosteroids, azathioprine, or 6-mercaptopurine (6-MP)?	Y N	
NOTE: Submission of medical records is required.		
[If no, no further questions.]		
18. Is the patient 18 years of age or older?	Y N	
[If yes, skip to question 25.]		
[If no, no further questions.]		

19. Is the patient 6 years of age or older?	Y N	
[If yes, skip to question 25.]		
[If no, no further questions.]		
20. Does the patient have any of the following diagnoses: A) sarcoidosis, B) graft-versus-host disease, C) interleukin-2 toxicity, D) Langerhans cell histiocytosis, E) myositis, F) nephrotic syndrome, G) amyloidosis, H) periodic fever syndrome, I) renal transplant syndrome, J) moderate to severe Crohn's disease in pediatric patient (as first line therapy), K) definitive radiographic axial spondyloarthritis with evidence of structural damage on sacroiliac joints?	Y N	
[If yes, no further questions.]		
21. Does the patient have one of the following diagnoses: A) psoriatic arthritis, B) plaque psoriasis?	Y N	
NOTE: Submission of medical records is required.		
[If no, skip to question 23.]		
22. Is the patient experiencing clinical improvement from treatment supported by one of the following outcomes: A) reduction in the signs and symptoms, B) prolonged beneficial clinical response, C) inhibition of structural damage progression, or D) improved physical functioning?	Y N	
NOTE: Submission of medical records is required.		
[If yes, skip to question 25.]		
[If no, no further questions.]		
23. Does the patient have one of the following diagnoses: A) Crohn's disease, B) ulcerative colitis?	Y N	
NOTE: Submission of medical records is required.		
[If no, no further questions.]		
24. Is the patient experiencing clinical improvement from treatment as supported by one of the following outcomes: A) reduction in gastrointestinal signs and symptoms, B) prolonged clinical remission and mucosal healing, or C) reduced number of draining enterocutaneous or rectovaginal fistulas for at least a 3-month period (only applies to fistulizing Crohn's disease)?	Y N	
NOTE: Submission of medical records is required.		
[If no, no further questions.]		
25. Is the requested drug being prescribed for FDA-approved dosages and dosing intervals?	Y N	
NOTE: Submission of medical records is required.		
[If no, no further questions.]		
26. Will the requested drug be used concurrently with another biologic disease-modifying anti-rheumatic drug (DMARD)?	Y N	

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

Prescriber (Or Authorized) Signature and Date