

Prior Authorization

JOHNS HOPKINS HEALTH PLANS (MEDICAID)

Stelara - 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 Stelara - Priority Partners MCO.

Drug Name (select from list of drugs shown)

Stelara (ustekinumab)

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 19.]

2. Does the patient have any of the following diagnoses: A) uveitis, B) sarcoidosis, C) graft-versus-host disease, D) interleukin-2 toxicity, E) Langerhan's cell histiocytosis, F) Y N

myositis, G) nephrotic syndrome, H) amyloidosis, I) periodic fever syndrome, J) renal transplant syndrome?	
[If yes, no further questions.]	
3. Does the patient have a diagnosis of active psoriatic arthritis?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If no, skip to question 7.]	
4. Has the patient tried and had insufficient response to at least two disease-modifying antirheumatic drugs (DMARDs) including methotrexate?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If yes, skip to question 6.]	
5. Does the patient have a contraindication to at least two disease-modifying antirheumatic drugs (DMARDs) including methotrexate?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
6. Has the patient tried and had insufficient response with either etanercept, adalimumab, or secukinumab?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If yes, skip to question 18.]	
[If no, no further questions.]	
7. Does the patient have a diagnosis of chronic moderate to severe plaque psoriasis?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If no, skip to question 13.]	
8. Does the patient have either of the following: A) body surface area involvement of greater than 5 percent, or B) body surface area involvement of less than or equal to 5 percent, but involves sensitive areas (palms/soles of feet, genitalia and head/neck)?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
9. Has the patient tried and had insufficient response to phototherapy or systemic disease-modifying anti-rheumatic drug (DMARD) therapy with methotrexate?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
10. Is the patient at least 12 years and less than 18 years of age?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If yes, skip to question 23.]	
11. Is the patient at least 18 years of age or older?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If no, no further questions.]	

12. Has the patient tried and had insufficient response to brodalumab, etanercept, adalimumab, or secukinumab?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If yes, skip to question 23.]	
[If no, no further questions.]	
13. Does the patient have a diagnosis of moderately to severely active Crohn's disease?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If no, skip to question 15.]	
14. Has the patient tried and had insufficient response with conventional therapies such as corticosteroids, or immunomodulators such as azathioprine, 6-mercaptopurine, or methotrexate?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If yes, skip to question 17.]	
[If no, no further questions.]	
15. Does the patient have a diagnosis of moderately to severely active ulcerative colitis?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
16. Has the patient tried and had insufficient response to immunosuppressants such as corticosteroids, azathioprine, or 6-mercaptopurine (6-MP)?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
17. Has the patient had treatment failure or intolerance to adalimumab?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
18. Is the patient 18 years of age or older?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If yes, skip to question 23.]	
[If no, no further questions.]	
19. Does the patient have one of the following diagnoses: A) active psoriatic arthritis, or B) chronic moderate to severe plaque psoriasis?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If no, skip to question 21.]	
20. 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?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	

[If yes, skip to question 23.]	
[If no, no further questions.]	
21. Does the patient have one of the following diagnoses: A) moderately to severely active Crohn's disease, or B) moderately to severely active ulcerative colitis?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
22. Is the patient experiencing clinical improvement from treatment 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)?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
23. Is the requested drug being prescribed for FDA-approved dosages and dosing intervals?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
24. Will the requested drug be used concurrently with another biologic disease-modifying anti-rheumatic drug (DMARD)?	<input type="checkbox"/> Y <input type="checkbox"/> 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