TRICARE Prior Authorization Request Form for
ustekinumab **(Stelara)**

JOHNS HOPKINS
HEALTH PLANS

7231 Parkway Drive, Suite 100, Hanover, MD 21076

FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

USFHP Pharmacy Prior Authorization Form

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Step 1 **Please complete patient and physician information** (please print):

Patient Name: _____ Physician Name: _____
Address: _____ Address: _____
_____ _____
Sponsor ID # _____ Phone #: _____
Date of Birth: Secure Fax #:

Step 2 **Please complete clinical assessment:**

1.	**What is the patient's age?**	☐ 18 years of age or older – proceed to question **2** ☐ 6 years of age to less than 18 years of age – proceed to question **3** ☐ Younger than 6 years of age – **STOP: coverage not approved.**
2.	**What is the indication or diagnosis for this adult patient?**	☐ Active psoriatic arthritis (PsA) – Proceed to question **5** ☐ Moderately to severely active Crohn's disease (CD) – Proceed to question **5** ☐ Moderately to severely active plaque psoriasis who are candidates for phototherapy or systemic – Proceed to question **5** ☐ Moderately to severely active ulcerative colitis (UC) – Proceed to question **4** ☐ Other indication or diagnosis – **STOP: coverage not approved.**
3.	**What is the indication or diagnosis for this pediatric patient?**	☐ Active psoriatic arthritis (PsA) – Proceed to question **5** ☐ Moderately to severely active plaque psoriasis who are candidates for phototherapy or systemic – Proceed to question **5** ☐ Other indication or diagnosis – **STOP: coverage not approved.**
4.	**Has the patient tried and failed, had an inadequate response, or had an adverse reaction to infliximab or adalimumab that is not expected to occur with Stelara?**	☐ Yes Proceed to question **9** ☐ No Proceed to question **5**
5.	**Does the provider acknowledge that brand adalimumab (Humira) is the Department of Defense's preferred targeted biologic agent and must be tried first for most indications?**	☐ Yes Proceed to question **6** ☐ No **STOP** **Coverage not approved**

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6. Has the patient had an inadequate response to Humira?	☐ Yes Proceed to question **9**	☐ No Proceed to question **7**
7. Has the patient experienced an adverse reaction to Humira that is not expected to occur with Stelara?	☐ Yes Proceed to question **9**	☐ No Proceed to question **8**
8. Does the patient have a contraindication to Humira (adalimumab)?	☐ Yes Proceed to question **9**	☐ No **STOP** **Coverage not approved**
9. Has the patient had an inadequate response to non-biologic systemic therapy (for example: methotrexate, aminosalicylates [for example: sulfasalazine, mesalamine], corticosteroids, immunosuppressants [for example: azathioprine])?	☐ Yes Proceed to question **10**	☐ No **STOP** **Coverage not approved**
10. Does the patient have evidence of a negative TB test result in the past 12 months (or TB is adequately managed)?	☐ Yes Proceed to question **11**	☐ No **STOP** **Coverage not approved**
11. Will the patient be receiving other targeted immunomodulatory biologics with Stelara, including but not limited to the following: Actemra, Cimzia, Cosentyx, Enbrel, Humira, Ilumya, Kevzara, Kineret, Olumiant, Orencia, Otezla, Remicade, Rinvoq ER, Rituxan, Siliq, Simponi, Skyrizi, Taltz, Tremfya or Xeljanz/Xeljanz XR?	☐ Yes **STOP** **Coverage not approved**	☐ No **Sign and date below**

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

Prescriber Signature _____ Date _____

[02 Oct 2024]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: