TRICARE Prior Authorization Request Form for
ustekinumab-auub (Wezlana), ustekinumab-kfce (Yesintek), ustekinumab-stba (Steqeyma), ustekinumab-aekn (Selarsdi), ustekinumab (Stelara) and ustekinumab-ttwe (Pyzchiva)



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.

Prior authorization does not expire.

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 the clinical assessment:**

1. **The provider acknowledges that the step-preferred product branded Otulfi is TRICARE's preferred ustekinumab product.**	☐ **Acknowledged** proceed to question **2**	
2. **How old is the patient?**	☐ Less than 6 years of age - **STOP - Coverage not approved** ☐ 6 to 17 years of age – proceed to question **3** ☐ 18 years of age or older – proceed to question **4**	
3. **What is the diagnosis or indication for pediatric patients (6 to 17 years of age)?**	☐ Active psoriatic arthritis - proceed to question **6** ☐ Moderate to severe plaque psoriasis who are candidates for phototherapy or systemic therapy – proceed to question **6** ☐ Other diagnosis – **STOP - Coverage not approved**	
4. **What is the diagnosis or indication for adult patients (18 years of age or older)?**	☐ Active psoriatic arthritis - proceed to question **6** ☐ Moderate to severe plaque psoriasis who are candidates for phototherapy or systemic therapy – proceed to question **6** ☐ Moderately to severely active Crohn's disease (CD) - proceed to question **5** ☐ Moderately to severely active ulcerative colitis (UC) - proceed to question **5** ☐ Other diagnosis – **STOP - Coverage not approved**	
5. **Has the patient used infliximab in lieu of Humira?**	☐ Yes proceed to question **11**	☐ No proceed to question **7**

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6. Has the patient had an inadequate response, intolerance, OR contraindication to nonbiologic systemic therapy (for example, methotrexate, aminosalicylates (for example, sulfasalazine, mesalamine), corticosteroids, immunosuppressants (for example, azathioprine)?	☐ Yes proceed to question **7**	☐ No **STOP** **Coverage not approved**
7. Humira is the Department of Defense's preferred targeted biologic agent. Has the patient tried Humira?	☐ Yes proceed to question **8**	☐ No proceed to question **10**
8. Has the patient had an inadequate response to Humira?	☐ Yes proceed to question **11**	☐ No proceed to question **9**
9. Has the patient experienced an adverse reaction to Humira that is not expected to occur with the requested agent?	☐ Yes proceed to question **11**	☐ No **STOP** **Coverage not approved**
10. Does the patient have a contraindication to Humira (adalimumab)?	☐ Yes proceed to question **11**	☐ No **STOP** **Coverage not approved**
11. Will the requested medication be used concomitantly with other targeted immunobiologics including but not limited to, TNF inhibitors, interleukins, JAK inhibitors?	☐ Yes **STOP** **Coverage not approved**	☐ No proceed to question **12**
12. Please provide patient-specific justification as to why the step-preferred branded Otulfi and the UF non-step-preferred products [ustekinumab-aauz (unbranded), Starjemza, Imuldosa] cannot be used in this patient.	_____ **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

[22 July 2026]

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