Mountain-Pacific Quality Health
Partnering within our communities to provide solutions for better health
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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).

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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**: _____

e. Provider attests to the following:
   - ☐ The member has been screened for teburculosis (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