USFHP Prior Authorization Request Form for **ustekinumab-aauz (Otulfi)**

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be faxed to 855-273-5735

OR

The patient may attach the completed form to the prescription and **mail** it to:

Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? Call 1-877-880-7007

https://www.usfamilyhealth.org/for-providers/pharmacy-information/

Prior authorization does not expire. Clinical documentation may be required.

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. What is the diagnosis or indication?	☐ Active psoriatic arthritis - proceed to question **3** ☐ Moderate to severe plaque psoriasis who are candidates for phototherapy or systemic therapy – proceed to question **3** ☐ Moderately to severely active Crohn's disease (CD) - proceed to question **2** ☐ Moderately to severely active ulcerative colitis (UC) - proceed to question **2** ☐ Other diagnosis – **STOP - Coverage not approved**	
2. Has the patient used infliximab in lieu of Humira?	☐ Yes proceed to question **8**	☐ No proceed to question **4**
3. 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 **4**	☐ No **STOP** **Coverage not approved**
4. Humira is the Department of Defense's preferred targeted biologic agent. Has the patient tried Humira?	☐ Yes proceed to question **5**	☐ No proceed to question **7**
5. Has the patient had an inadequate response to Humira?	☐ Yes proceed to question **8**	☐ No proceed to question **6**

Question	Yes	No
6. Has the patient experienced an adverse reaction to Humira that is not expected to occur with the requested agent?	☐ Yes proceed to question **8**	☐ No **STOP** **Coverage not approved**
7. Does the patient have a contraindication to Humira (adalimumab)?	☐ Yes proceed to question **8**	☐ No **STOP** **Coverage not approved**
8. 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 **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 ________

[20 May 2026]