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

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 clinical assessment:**

1. The provider acknowledges that Taltz is available for treatment of plaque psoriasis without the requirement to try Humira.	☐ Acknowledged Proceed to question **2**
2. What is the patient's age?	☐ 18 years of age or older – proceed to question **3** ☐ 6 to 17 years of age – proceed to question **4** ☐ Younger than 6 years of age – **STOP: coverage not approved.**
3. What is the indication or diagnosis for this adult patient?	☐ Active psoriatic arthritis (PsA) – Proceed to question **5** ☐ Moderate to severe plaque psoriasis who are candidates for phototherapy or systemic therapy – Proceed to question **5** ☐ Moderately to severely active Crohn's disease (CD) – Proceed to question **6** ☐ Moderately to severely active ulcerative colitis (UC**)** – Proceed to question **6** ☐ Other indication or diagnosis – **STOP: coverage not approved.**
4. What is the indication or diagnosis for this pediatric patient?	☐ Active psoriatic arthritis (PsA) – Proceed to question **5** ☐ Moderate to severe plaque psoriasis who are candidates for phototherapy or systemic therapy – Proceed to question **5** ☐ Other indication or diagnosis – **STOP: coverage not approved.**

5. Has the patient had an inadequate response, intolerance, or contraindication to non-biologic systemic therapy [for example: methotrexate, aminosalicylates (for example: sulfasalazine, mesalamine), corticosteroids, immunosuppressants (for example: azathioprine)]?	☐ Yes Proceed to question **6**	☐ No **STOP** **Coverage not approved**
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. Will the patient be receiving other targeted immunomodulatory biologics with Stelara, including but not limited to: TNF inhibitors, IL-1, IL-6, IL17, IL-23, IL-36, S1p, 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 _____