US Family Health Plan
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**

Medical documentation must be attached. Failure to provide could result in denial.

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. Humira is the Department of Defense's preferred targeted biologic agent. Has the patient tried Humira?	☐ Yes Proceed to question **2**	☐ No Proceed to question **4**
2. Has the patient had an inadequate response to Humira?	☐ Yes Proceed to question **7**	☐ No Proceed to question **3**
3. Has the patient experienced an adverse reaction to Humira that is not expected to occur with the requested agent?	☐ Yes Proceed to question **7**	☐ No Proceed to question **4**
4. Does the patient have a contraindication to Humira (adalimumab)?	☐ Yes Proceed to question **7**	☐ No Proceed to question **5**
5. What is the indication or diagnosis?	☐ Active **psoriatic arthritis** in patients between 6 and 17 years of age – Proceed to question **10** ☐ oderately to severely active **plaque psoriasis** in patients between 6 and 17 years of age – Proceed to question **10** ☐ Moderately to severely active **ulcerative colitis (UC)** – Proceed to question **6** ☐ Other indication or diagnosis – **STOP: coverage not approved.**	
6. Has the patient tried and failed or had an inadequate response to infliximab (Remicade)?	☐ Yes Proceed to question **8**	☐ No **STOP** **Coverage not approved**
7. Is the requested medication being prescribed for active psoriatic arthritis OR moderately to severely active plaque psoriasis in patients between 6 and 17 years of age?	☐ Yes Proceed to question **10**	☐ No Proceed to question **8**
8. Is the patient 18 years of age or older?	☐ Yes Proceed to question **9**	☐ No **STOP** **Coverage not approved**

9. What is the indication or diagnosis in this adult patient?	☐ Active **psoriatic arthritis (PsA)** alone or in combination with methotrexate – Proceed to question **10** ☐ Moderately to severely active **Crohn's disease (CD)** – Proceed to question **10** ☐ Moderately to severely active **plaque psoriasis** who are candidates for phototherapy or systemic – Proceed to question **10** ☐ Moderately to severely active **ulcerative colitis (UC)** – Proceed to question **10** ☐ Other indication or diagnosis – **STOP: coverage not approved.**	
10. 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 **11**	☐ No **STOP** **Coverage not approved**
11. 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 **12**	☐ No **STOP** **Coverage not approved**
12. 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 _____