US Family Health Plan
Prior Authorization Request Form for
Ustekinumab-auub (Wezlana), Ustekinumab-kfce (Yesintek), and Ustekinumab-stba (Steqeyma)

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**

Clinical documentation may be required for review.
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. How old is the patient?	☐ Less than 6 years of age - **STOP - coverage not approved.** ☐ 6 to 17 years of age – proceed to question **2** ☐ 18 years of age or older – proceed to question **3**	
2. What is the diagnosis or indication for pediatric patients (6 to 17 years of age)?	☐ Active psoriatic arthritis - proceed to question **5** ☐ Moderate to severe plaque psoriasis who are candidates for phototherapy or systemic therapy – proceed to question **5** ☐ Other diagnosis – **STOP - coverage not approved.**	
3. What is the diagnosis or indication for adult patients (18 years of age or older)?	☐ Active psoriatic arthritis - 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 **4** ☐ Moderately to severe ulcerative colitis (UC) - proceed to question **4** ☐ Other diagnosis – **STOP - coverage not approved.**	
4. Has the patient had a trial of intravenous (IV) infliximab?	☐ Yes proceed to question **10**	☐ No proceed to question **6**

5. 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 **6**	☐ No **STOP** **Coverage not approved**
6. Humira is the Department of Defense's preferred targeted biologic agent. Has the patient tried Humira?	☐ Yes proceed to question **7**	☐ No proceed to question **9**
7. Has the patient had an inadequate response to Humira?	☐ Yes proceed to question **10**	☐ No proceed to question **8**
8. Has the patient experienced an adverse reaction to Humira that is not expected to occur with the requested agent?	☐ Yes proceed to question **10**	☐ No **STOP** **Coverage not approved**
9. Does the patient have a contraindication to Humira (adalimumab)?	☐ Yes proceed to question **10**	☐ No **STOP** **Coverage not approved**
10. Will the requested medication be used concomitantly with other TIBs including, but not limited to: TNF inhibitors, IL-1, IL-6, IL-17, 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 _____