

USFHP Prior Authorization Request Form for  
**ustekinumab-auub (Wezlana), ustekinumab-kfce (Yesintek), ustekinumab-stba (Steqeyma),  
ustekinumab-aekn (Selarsdi ), ustekinumab (Stelara) and ustekinumab-ttwe (Pyzchiva)**

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):**

<b>1</b>	Patient Name: _____	Physician Name: _____
	Address: _____	Address: _____
	Sponsor ID #: _____	Phone #: _____
	Date of Birth: _____	Secure Fax #: _____

**Step 2 Please complete the clinical assessment:**

<b>2</b>	1. How old is the patient?	<input type="checkbox"/> Less than 6 years of age - <b>STOP - Coverage not approved</b> <input type="checkbox"/> 6 to 17 years of age – proceed to question 2 <input type="checkbox"/> 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)?	<input type="checkbox"/> Active psoriatic arthritis - proceed to question 5 <input type="checkbox"/> Moderate to severe plaque psoriasis who are candidates for phototherapy or systemic therapy – proceed to question 5 <input type="checkbox"/> Other diagnosis – <b>STOP - Coverage not approved</b>		
	3. What is the diagnosis or indication for adult patients (18 years of age or older)?	<input type="checkbox"/> Active psoriatic arthritis - proceed to question 5 <input type="checkbox"/> Moderate to severe plaque psoriasis who are candidates for phototherapy or systemic therapy – proceed to question 5 <input type="checkbox"/> Moderately to severely active Crohn's disease (CD) - proceed to question 4 <input type="checkbox"/> Moderately to severely active ulcerative colitis (UC) - proceed to question 4 <input type="checkbox"/> Other diagnosis – <b>STOP - Coverage not approved</b>		
	4. Has the patient used infliximab in lieu of Humira?	<table border="0" style="width: 100%;"> <tr> <td style="width: 50%; text-align: center;"> <input type="checkbox"/> Yes proceed to question 10 </td> <td style="width: 50%; text-align: center;"> <input type="checkbox"/> No proceed to question 6 </td> </tr> </table>	<input type="checkbox"/> Yes proceed to question 10	<input type="checkbox"/> No proceed to question 6
<input type="checkbox"/> Yes proceed to question 10	<input type="checkbox"/> No proceed to question 6			

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ustekinumab-auub (Wezlana), ustekinumab-kfce (Yesintek), ustekinumab-stba (Steqeyma),  
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<p><b>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)?</b></p>	<p style="text-align: center;"><input type="checkbox"/> Yes proceed to question <b>6</b></p>	<p style="text-align: center;"><input type="checkbox"/> No <b>STOP</b> Coverage not approved</p>
<p><b>6. Humira is the Department of Defense's preferred targeted biologic agent. Has the patient tried Humira?</b></p>	<p style="text-align: center;"><input type="checkbox"/> Yes proceed to question <b>7</b></p>	<p style="text-align: center;"><input type="checkbox"/> No proceed to question <b>9</b></p>
<p><b>7. Has the patient had an inadequate response to Humira?</b></p>	<p style="text-align: center;"><input type="checkbox"/> Yes proceed to question <b>10</b></p>	<p style="text-align: center;"><input type="checkbox"/> No proceed to question <b>8</b></p>
<p><b>8. Has the patient experienced an adverse reaction to Humira that is not expected to occur with the requested agent?</b></p>	<p style="text-align: center;"><input type="checkbox"/> Yes proceed to question <b>10</b></p>	<p style="text-align: center;"><input type="checkbox"/> No <b>STOP</b> Coverage not approved</p>
<p><b>9. Does the patient have a contraindication to Humira (adalimumab)?</b></p>	<p style="text-align: center;"><input type="checkbox"/> Yes proceed to question <b>10</b></p>	<p style="text-align: center;"><input type="checkbox"/> No <b>STOP</b> Coverage not approved</p>
<p><b>10. Will the requested medication be used concomitantly with other targeted immunobiologics including but not limited to, TNF inhibitors, interleukins, JAK inhibitors?</b></p>	<p style="text-align: center;"><input type="checkbox"/> Yes <b>STOP</b> Coverage not approved</p>	<p style="text-align: center;"><input type="checkbox"/> No proceed to question <b>11</b></p>
<p><b>11. Please provide patient-specific justification as to why the step-preferred ustekinumab-auub (Otulfi) and the UF non-step-preferred products (unbranded Otulfi, Starjemza, Imuldosa) cannot be used in this patient.</b></p>	<p>_____</p> <p><b>Sign and date below</b></p>	

**Step 3** I certify the above is true to the best of my knowledge. Please sign and date:

\_\_\_\_\_

Prescriber Signature

\_\_\_\_\_

Date