SENDERO HEALTH PLANS

Prior Authorization Request Form	Stelara
Sendero Fax: 512-901-9724	**Phone:** 855-297-9191
URGENCY: ☐ **STANDARD**	☐ **URGENT (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health or ability to regain maximum function)**

Provider Information	Patient Information
Referring/Prescribing Physician: ☐ **PCP** ☐ **Specialist** **Name:** **Please identify SPECIALTY:** **DEA, NPI or TIN:** **Contact:** **Phone: ( ) Fax: ( )**	**Patient's Name:** **Birth Date:** **ID Number:** **Phone Number:** **Patient Height:** **Patient Weight:**

Indicate where the drug is being DISPENSED	Indicate where the drug is being ADMINISTERED
☐ **Ambulatory Surgery Center**	☐ **Ambulatory Surgery Center**
☐ **Home Care Agency**	☐ **Inpatient Hospital**
☐ **Inpatient Hospital**	☐ **Long Term Care**
☐ **Long Term Care**	☐ **Outpatient Hospital**
☐ **Outpatient Hospital**	☐ **Patient's Home**
☐ **Patient's Home**	☐ **Pharmacy**
☐ **Pharmacy**	☐ **Physician's Office**
☐ **Physician's Office**	☐ **Other (explain):**
☐ **Other (explain):**	**Anticipated Date of Service:**

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

PATIENT CLINICAL INFORMATION

CRITERIA QUESTIONS:

1. Has the patient been diagnosed with any of the following?
   - ☐ Psoriasis
   - ☐ Psoriatic arthritis
   - ☐ Crohn's disease
   - ☐ Ulcerative colitis
   - ☐ Other: _____

2. What is the HCPCS code? _____ What is the ICD-10 code? _____
   What is the NDC#: _____

3. What is the prescribed dose and frequency?
   - ☐ Stelara SQ 45mg Frequency: _____
   - ☐ Stelara SQ 90mg Frequency: _____
   - ☐ Stelara SQ 0.75mg/kg = _____(weight < 60kg) Frequency: _____
   - ☐ Stelara IV x1 dose ☐ 260mg ☐ 390mg ☐ 520mg, followed by maintenance Stelara SQ 90mg every 8 weeks

4. Will the requested drug be used in combination with any other biologic or targeted synthetic DMARD (e.g., Olumiant, Xeljanz)? ☐ Yes ☐ No

5. Has the patient had a TB screening test (e.g., a tuberculosis skin test [PPD] or an interferon-release assay [IGRA]) within 6 months of initiating therapy? ☐ Yes ☐ No

6. What were the results of the TB screening test? ☐ Positive ☐ Negative

7. Does the patient have latent or active tuberculosis (TB)? ☐ Latent ☐ Active ☐ No/Neither

8. If the patient has latent or active tuberculosis, has treatment been initiated or completed?
   ☐ Yes - treatment initiated ☐ Yes - treatment completed ☐ No

9. Is this request for continuation of therapy? ☐ Yes ☐ No

10. For continuation of therapy requests, has the patient achieved or maintained positive clinical response as evidenced by low disease activity or improvement in signs and symptoms since starting treatment with the requested drug? ☐ Yes ☐ No

11. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program? ☐ Yes ☐ No

DIAGNOSIS QUESTIONS: ***Please only complete sections below that are relevant to the patient's diagnosis.***

Section A. Psoriasis

12. The patient is diagnosed with psoriasis and treatment is prescribed by or in consultation with a dermatologist or rheumatologist ☐ Yes ☐ No

13. Has the patient previously received Otezla or any other biologic medication indicated for the treatment of moderate to severe plaque psoriasis? ☐ Yes ☐ No If Yes, please indicate the drug, duration, response, and intolerance/contraindication if applicable:
    _____

14. Has the patient had an inadequate response to 1 or more of the following topical therapies?
    - ☐ Corticosteroids (e.g., betamethasone, clobetasol, desonide) (4-week trial)
    - ☐ Vitamin D analogs (e.g., calcitriol, calcipotriene)
    - ☐ Tazarotene
    - ☐ Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus)
    - ☐ Anthralin
    - ☐ Coal tar

15. Has the patient had an inadequate response to a minimum 3 month trial of methotrexate at a minimum dose of 15mg po weekly within the last 6 months? ☐ Yes ☐ No

16. Does the patient have a contraindication or intolerance to methotrexate? ☐ Yes ☐ No If Yes, indicate contraindication/intolerance and no further questions. _____

17. Does the patient have severe psoriasis that warrants a biologic DMARD as first-line therapy (i.e. at least 10% of the body surface area (BSA) or crucial body areas (e.g., hands, feet, face, neck, scalp, genitals/groin, intertriginous areas) are affected)? ☐ Yes ☐ No

* Please note, the preferred biologic class is a TNF inhibitor (specifically Humira), followed by anti-IL-17 (specifically Siliq). The preferred anti-IL-12/23 is Skyrizi. Please consider prescribing one of these drugs if clinically appropriate. If Stelara is preferred, please provide additional clinical reasoning documentation here:
_____

Section B: Psoriatic Arthritis

18. The patient is diagnosed with psoriatic arthritis and treatment is prescribed by or in consultation with a rheumatologist ☐ Yes ☐ No

19. Has the patient previously received a biologic medication, apremilast (Otezla), or targeted synthetic DMARD (e.g., Xeljanz) indicated for the treatment of psoriatic arthritis? ☐ Yes ☐ No ☐ Yes ☐ No If Yes, please indicate the drug, duration, response, and intolerance/contraindication if applicable:
    _____

20. Has the patient experienced an inadequate response after at least 3 months of treatment with 1 or more of the following medications at the maximally tolerated dose?
    - ☐ Methotrexate – minimum dose 15mg po weekly
    - ☐ Sulfasalazine – minimum dose 2g po weekly

- ☐ Cyclosporine
- ☐ Leflunomide
- ☐ Apremilast (Otezla)

Does the patient have a contraindication or intolerance to at least 2 options listed above? ☐ Yes ☐ No If yes, please document medications and respective contraindications/intolerances:

_____

* Please note, the preferred biologic class is a TNF inhibitor (specifically Cimzia), followed by anti-IL-17 (specifically Siliq) or Orencia. The preferred anti-12/23 is Tremfya. Please consider prescribing 1 of these drugs before Stelara if clinically appropriately. If Stelara is preferred over these agents, please provide additional clinical reasoning documentation here:

_____

Section B: Crohn's Disease

21. There is documentation of moderate to severe Crohn's disease per the Crohn's Disease Activity index (CDAI):
    - ☐ Mild = CDAI <220
    - ☐ Moderate = CDAI 220-450
    - ☐ Severe = CDAI >450

22. There is documentation of 1 or more of the following high-risk features:
    - ☐ Diagnosis at age <30 years
    - ☐ Ileal disease
    - ☐ Penetrating or stricturing disease
    - ☐ Perianal or severe rectal disease
    - ☐ Extra-intestinal manifestations
    - ☐ History of bowel resections
    - ☐ Initial extensive bowel involvement on endoscopy
    - ☐ None

23. The treatment is prescribed by or in consultation with a gastroenterologist ☐ Yes ☐ No

24. Has the patient previously received a biologic indicated for Crohn's disease? ☐ Yes ☐ No
    If Yes, please indicate the drug, duration, response, and intolerance/contraindication if applicable:
    _____

25. Does the patient have perianal or fistulizing Crohn's disease? ☐ Yes ☐ No

26. Has the patient had an inadequate response to a minimum 3 month trial at the maximally indicated dose of 1 or more of the following therapies within the last 6 months? If Yes, indicate below and no further questions.
    - ☐ Sulfasalazine
    - ☐ Mesalamine (if primarily colonic disease)
    - ☐ Azathioprine at minimum dose 1.5 mg/kg daily
    - ☐ 6-mercaptopurine at minimum dose 50mg daily
    - ☐ Methotrexate at minimum dose 15mg **IM or SQ** weekly
    - ☐ Systemic corticosteroids (e.g., prednisone, methylprednisolone)
    - ☐ None of the above therapies have been trialed

27. Does the patient have a contraindication or intolerance to at least 2 options listed above? ☐ Yes ☐ No
    If yes, please document medications and respective contraindications/intolerances:
    _____

* Please note, the preferred biologic class is a TNF inhibitor (specifically Cimzia, followed by Humira, followed by infliximab). Please consider prescribing one of these drugs before Stelara if clinically appropriate. If Stelara is preferred, please provide additional clinical reasoning documentation here:

_____

Section C: Ulcerative Colitis

28. There is a diagnosis of moderate to severe ulcerative as evidenced by one of the following:
    - ☐ >4 loose and/or bloody bowel movements per day
    - ☐ Evidence of systemic toxicity (e.g., fever, tachycardia, anemia with Hgb<10.0 g/dL, weight loss, and/or elevated CRP or ESR).
    - ☐ Endoscopic findings of marked erythema, absent vascular pattern, friability, erosions, spontaneous bleeding, and/or ulceration (e.g., findings consistent with a Mayo endoscopic sub score of at least 2, or Ulcerative Colitis Endoscopic Index of Severity of at least 5)
    - ☐ Patients with corticosteroid dependent or corticosteroid refractory disease
    - ☐ Patients at high risk for colectomy with clinical documentation of risk by prescribing provider

29. The treatment is prescribed by or in consultation with a gastroenterologist ☐ Yes ☐ No

30. Has the patient previously received a biologic or targeted synthetic disease modifying drug (e.g., Xeljanz) indicated for moderately to severely active ulcerative colitis? ☐ Yes ☐ No
    If Yes, please indicate the drug, duration, response, and intolerance/contraindication if applicable:
    _____

31. Has the patient been hospitalized for acute severe ulcerative colitis (e.g., continuous bleeding, severe toxic symptoms, including fever and anorexia)? ☐ Yes ☐ No

32. Has the patient had an inadequate response to a minimum 2 month trial at the maximally indicated dose of 1 or more of the following within the last 6 months? If Yes, indicate below and no further questions.
    - ☐ Oral 5-aminosalycylic acid (e.g., sulfasalazine, mesalamine) at a minimum dose of 2g daily
    - ☐ Rectal 5-aminosalycylic acid enemas with minimum dose of 1g daily
      * Note: failure of rectal 5-ASA suppositories alone will not meet criteria for biologic
    - ☐ Budesonide
    - ☐ Thiopurines (e.g., azathioprine, 6-mercaptopurine)
    - ☐ Methotrexate with a minimum dose of 15mg IM or SQ weekly
    - ☐ Systemic corticosteroids (e.g., prednisone, methylprednisolone)
    - ☐ None of the above therapies have been trialed

33. Does the patient have a contraindication or intolerance to at least 2 options listed above? ☐ Yes ☐ No
    If yes, please document medications and respective contraindications/intolerances:
    _____

* Please note, the preferred biologic is a TNF inhibitor (specifically Simponi, followed by Humira, followed by infliximab) or Xeljanz; followed by Entyvio. Please consider prescribing 1 of these agents if clinically appropriate. If Stelara is preferred, please provide additional clinical reasoning documentation here:

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_____

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by Sendero Health Plans.	
Prescriber or Authorized Signature	DATE