

## Immunomodulators: Stelara

### Member Information

1. Member Last Name: \_\_\_\_\_ 2. First Name: \_\_\_\_\_  
3. Member ID #: \_\_\_\_\_ 4. Member Date of Birth: \_\_\_\_\_ 5. Member Gender: \_\_\_\_\_

### Prescriber Information

6. Prescribing Provider NPI #: \_\_\_\_\_  
7. Requester Contact Information - Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ Ext. \_\_\_\_\_

### Drug Information

8. Drug Name: \_\_\_\_\_ 9. Strength: \_\_\_\_\_ 10. Quantity Per 30 Days: \_\_\_\_\_  
11. Length of Therapy (in days): ☐ up to 30 Days ☐ 60 Days ☐ 90 Days ☐ 120 Days ☐ 180 Days ☐ 365 Days ☐  
Other \_\_\_\_\_

### Clinical Information

#### Request for Crohn's Disease (Adult)

1. Does the member have a diagnosis of moderate to severe Crohn's Disease? ☐ Yes ☐ No
2. Is the member not on another injectable biologic immunomodulator? ☐ Yes ☐ No
3. Have the member been considered and screened for the presence of latent tuberculosis infection? ☐ Yes ☐ No
4. Have the member been tested with Hep B SAG and Core Ab? ☐ Yes ☐ No
5. Have the member had a trial and failure of Humira or a clinical reason member cannot try Humira? ☐ Yes ☐ No

#### Request for Plaque Psoriasis (Adult)

1. Does the member have a documented definitive diagnosis of moderate-to-severe Chronic Plaque Psoriasis? ☐ Yes ☐ No
2. Is the member 18 years of age or older? ☐ Yes ☐ No
3. Is the member not on another injectable biologic immunomodulator? ☐ Yes ☐ No
4. Have the member been considered and screened for the presence of latent tuberculosis infection (not required for Otezla)? ☐ Yes ☐ No
5. Have the member been tested with Hep B SAG and Core Ab? ☐ Yes ☐ No
6. Does the member have a body surface area (BSA) involvement of at least 3%? ☐ Yes ☐ No
7. Does the member have involvement of the palms, soles, head and neck, or genitalia, causing disruption in normal daily activities and/or employment? ☐ Yes ☐ No
8. Have the member failed to respond to, or has been unable to tolerate phototherapy and **ONE** of the following medications or member has contraindications to these treatments: Soriatane (acitretin), Methotrexate, and/or Cyclosporine? ☐ Yes ☐ No
9. Has the member had a trial and failure of Cosentyx, Enbrel or Humira or a clinical reason member cannot try Cosentyx, Enbrel or Humira? ☐ Yes ☐ No

**Request for Plaque Psoriasis (Pediatric): (ages 6 and up)**

1. Does the member have a diagnosis of plaque psoriasis and is a candidate for systemic therapy phototherapy?  
☐ Yes ☐ No
2. Is the member not on another injectable biologic immunomodulator? ☐ Yes ☐ No
3. Have the member been considered and screened for the presence of latent tuberculosis infection? ☐ Yes ☐ No
4. Have the member been tested with Hep B SAG and Core Ab? ☐ Yes ☐ No
5. Have the member experienced a therapeutic failure/inadequate response with or has a contraindication or intolerance to methotrexate? ☐ Yes ☐ No
6. Does the member have a body surface area (BSA) involvement of at least 3%? ☐ Yes ☐ No
7. Does the member have involvement of the palms, soles, head and neck, or genitalia, causing disruption in normal daily activities and/or employment? ☐ Yes ☐ No
8. For ages 6 and up, has the member had a trial and failure of Cosentyx, Enbrel or a clinical reason member cannot try Cosentyx, Enbrel or Humira? ☐ Yes ☐ No

**Request for Psoriatic Arthritis**

1. Does the member have a documented definitive diagnosis of Psoriatic Arthritis? ☐ Yes ☐ No
2. Is the member 6 years of age or older? ☐ Yes ☐ No
3. Is the member not on another injectable biologic immunomodulator? ☐ Yes ☐ No
4. Has the member been considered and screened for the presence of latent tuberculosis infection? ☐ Yes ☐ No
5. Has the member been tested with Hep B SAG and Core Ab? ☐ Yes ☐ No
6. Does the member have a documented inadequate response or inability to take methotrexate? ☐ Yes ☐ No
7. Has the member had a trial and failure of Cosentyx, Enbrel or Humira or a clinical reason member cannot try Cosentyx, Enbrel or Humira? ☐ Yes ☐ No

**Request for Ulcerative Colitis (Adult)**

1. Does the member have a diagnosis of ulcerative colitis? ☐ Yes ☐ No
2. Is the member not on another injectable biologic immunomodulator? ☐ Yes ☐ No
3. Has the member been considered and screened for the presence of latent tuberculosis? ☐ Yes ☐ No
4. Has the member been tested with Hep B SAG and Core Ab? ☐ Yes ☐ No
5. Has the member had a trial and failure of Humira or a clinical reason member cannot try Humira? ☐ Yes ☐ No

Signature of Prescriber: \_\_\_\_\_ Date: \_\_\_\_\_

**(Prescriber Signature Mandatory)**

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.