OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.
Visit go.covermymeds.com/OptumRx to begin using this free service.
Please note: All information below is required to process this request.
Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Stelara® Prior Authorization Request Form (Page 1 of 2)

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Member Information (required)

Member Name:		
Insurance ID#:		
Date of Birth:		
Street Address:		
City:	State:	Zip:
Phone:		

Provider Information (required)

Provider Name:		
NPI#:	Specialty:	
Office Phone:		
Office Fax:		
Office Street Address:		
City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

- ❑ Active psoriatic arthritis
- ❑ Moderate to severe plaque psoriasis
- ❑ Moderately to severely active Crohn's disease
- ❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical Information:

Please document the patient's weight: _____lbs/kg

Select if Stelara is prescribed by or in consultation with one of the following specialists:

- ❑ Dermatologist
- ❑ Gastroenterologist
- ❑ Rheumatologist

Is the patient receiving Stelara in combination with a biologic DMARD (e.g., Enbrel [etanercept], Humira [adalimumab], Cimzia [certolizumab], Simponi [golimumab])? ❑ **Yes** ❑ **No**

For moderately to severely active Crohn's disease, also answer the following:

Has the patient had trial and failure, contraindication or intolerance to at least one tumor necrosis factor (TNF) blocker (e.g., Remicade/Inflectra [infliximab], Humira [adalimumab], Cimzia [certolizumab pegol])? ❑ **Yes** ❑ **No**

Has the patient had trial and failure, contraindication or intolerance to treatment with at least one immunomodulator or corticosteroid (e.g., Purinethol [6-mercaptopurine], Imuran [azathioprine], Sandimmune [cyclosporine A], Prograf [tacrolimus], MTX [methotrexate])? ❑ **Yes** ❑ **No**

Is this for continuation of prior Stelara therapy? ❑ **Yes** ❑ **No**

For intravenous (IV) Stelara, answer the following:

Is Stelara to be administered as an intravenous induction dose? ❑ **Yes** ❑ **No**

Select the induction dosing that will be used in accordance with the United States Food and Drug Administration approved labeled dosing for Crohn's disease:

- ❑ 260 mg for patients weighing 55 kg or less
- ❑ 390 mg for patients weighing more than 55 kg to 85 kg
- ❑ 520 mg for patients weighing more than 85 kg

Reauthorization:

If this is a reauthorization request, answer the following questions:

Is there documentation the patient has had a positive clinical response to Stelara therapy? ❑ **Yes** ❑ **No**

Is the patient receiving Stelara in combination with a biologic DMARD (e.g., Enbrel [etanercept], Humira [adalimumab], Cimzia [certolizumab], Simponi [golimumab])? ❑ **Yes** ❑ **No**

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Stelara® Prior Authorization Request Form (Page 2 of 2)

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Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

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