OPTUMRx®

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)

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			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
❑ Moderately to severely active Crohn's disease
❑ Moderate to severe plaque psoriasis
❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical Information:

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

Document patient's weight: _____ (lbs/kg)

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

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

❑ Dermatologist
❑ Gastroenterologist
❑ Rheumatologist

Select if the patient has had trial and failure, contraindication, or intolerance to the following, as appropriate for the patient's diagnosis:

❑ Cimzia (certolizumab)
❑ Cosentyx (secukinumab)
❑ Enbrel (etanercept)
❑ Humira (adalimumab)
❑ Remicade/Infectra (infliximab)
❑ Other: _____

For active psoriatic arthritis, also answer the following:

If this request is for a dose of 90 mg/mL, does the patient have co-exisitent moderate to severe psoriasis? ❑ **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 treatment with at least one immunomodulator or corticosteroid [e.g., Purinethol (6-mercaptopurine), Imuran (azathioprine), Sandimmune (cyclosporine A), Prograf (tacrolimus), MTX/Trexall/Rheumatrex (methotrexate)]? ❑ **Yes** ❑ **No**

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

If using intravenous Stelara, select the dose below to verify the Stelera induction dosing is 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 weight more than 55 kg to 85 kg
❑ 520 mg for patients weighing more than 85 kg

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

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

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**

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

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.
If the patient is not able to meet the above standard prior authorization requirements, please call 1-800-711-4555.
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.