Medical drug benefit Prior authorization request



Stelara Version20 Effective: 07/10/2023

Phone: 877-417-1839 (NH Medicaid) Fax: 866-539-7185

Date:

* Some plans might not accept this form for Medicare or Medicaid requests

This form is being used for:	
Check if Expedited Review/Urgent Request:	☐ (In checking this box, I attest to the fact that this request meets the definition and criteria for expedited review and is an urgent request.)

1. Patient Information	
Patient Name:	DOB:

Member ID #:

2. Prescriber Information		
Prescribing Clinician:	Phone #:	
Specialty:	Secure Fax #:	
NPI#:	DEA/xDEA:	
Prescriber Point of Contact Name (POC) (if different than provider):		
POC Phone #:	POC Secure Fax #:	
POCEmail (notrequired):		

Prescribing Clinician or Authorized Representative Signature:

3. Requested Dosing

Please document the requested dosing:

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4. Member's weight in kg

Please document the member's weight in kg:

5. Concurrent use

Will the member be using the requested medication concurrently with a biologic or a targeted synthetic DMARD?

🛛 Yes

🗌 No

6. Other conditions

Does the member have any of the following? Please choose any of the following that apply:

□ Children or adolescents < 18 years of age

□ Plaque psoriasis

□ Psoriatic arthritis

 \Box None of the above

7. Diagnosis

What is the diagnosis the requested medication is being used to treat (select ONE)

 \Box Crohn's disease

□ Ulcerative colitis

□ Other, please indicate diagnosis below and include supporting clinical documentation for use in this indication and attached applicable chart notes in faxed request

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8. Crohn's disease

If the selected diagnosis is Crohn's disease, please select **all** of the following that apply:

 $\hfill\square$ The requested medication will be used as induction therapy

□ Member has tried or is currently taking a systemic corticosteroid, or a systemic corticosteroid is contraindicated

□ Member has tried one conventional systemic therapy (e.g. azathioprine, 6-mercaptopurine, or methotrexate)

 \Box Member has enterocutaneous (perianal or abdominal) or rectovaginal fistulas

 \Box Member had ileocolonic resection

 \Box Other (please specify):

9. Ulcerative colitis

If the selected diagnosis is ulcerative colitis, please select **all** that apply

□ The medication will be used as induction therapy

□ Member has tried one systemic therapy (e.g. 6-mercaptopurine, azathioprine, cyclosporine, tacrolimus, or a corticosteroid)

 \Box Other (please specify):

10. Specialty of the prescriber

Please indicate what specialty the prescriber is (select any that apply):

□ Gastroenterologist

□ Other (please indicate what specialty below):

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22. HCPCS Codes

Please document the applicable HCPCS codes (e.g. J codes or Q codes) being requested, including the number of units and number of visits (*using the space below*):

□ HCPCS / Qcodes:

 \Box Number of units:

 \Box Number of visits:

Providers should consult the health plan's coverage policies, member benefits, and medical necessity guidelines to complete this form. Providers may attach any additional data relevant to medical necessity criteria.

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