Medical drug benefit
Prior authorization request

WellSense HEALTH PLAN

Stelara
Version20 Effective: 07/10/2023

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

* 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 #:
POC Email (not required):	
Prescribing Clinician or Authorized Representative Signature:	Date:

3. Requested Dosing
Please document the requested dosing:

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
- ☐ None of the above

7. Diagnosis

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

- ☐ 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

8. Crohn's disease

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

☐ 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)

☐ Member has enterocutaneous (perianal or abdominal) or rectovaginal fistulas

☐ Member had ileocolonic resection

☐ 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)

☐ 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:
- ☐ Number of units:
- ☐ 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.