Stelara and biosimilars

CareFirst Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-855-330-1720**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-888-877-0518.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Referring Provider Info: ❑ Same as Requesting Provider
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Rendering Provider Info: ❑ Same as Referring Provider ❑ Same as Requesting Provider
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Required Demographic Information:

Patient Weight: _____*kg*

Patient Height: _____*cm*

Please indicate the place of service for the requested drug:

❑ *Ambulatory Surgical*	❑ *Home*	❑ *Off Campus Outpatient Hospital*
❑ *On Campus Outpatient Hospital*	❑ *Office*	❑ *Pharmacy*

What is the ICD-10 code? _____

What product is being requested? ❑ Stelara IV ❑ Stelara SC ❑ Imuldosa IV ❑ Imuldosa SC
❑ Otulfi IV ❑ Otulfi SC ❑ Pyzchiva IV ❑ Pyzchiva SC ❑ Selarsdi IV ❑ Selarsdi SC
❑ Starjemza IV ❑ Starjemza SC ❑ Steqeyma IV ❑ Steqeyma SC
❑ Ustekinumab (unbranded Stelara) IV ❑ Ustekinumab (unbranded Stelara) SC
❑ Ustekinumab-aauz (unbranded Otulfi) IV ❑ Ustekinumab-aauz (unbranded Otulfi) SC
❑ Ustekinumab-aekn (unbranded Selarsdi) IV ❑ Ustekinumab-aekn (unbranded Selarsdi) SC
❑ Ustekinumab-stba (unbranded Steqeyma) IV ❑ Ustekinumab-stba (unbranded Steqeyma) SC
❑ Ustekinumab-ttwe (unbranded Pyzchiva) IV ❑ Ustekinumab ttwe (unbranded Pyzchiva) SC
❑ Wezlana IV ❑ Wezlana SC ❑ Yesintek IV ❑ Yesintek SC

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720

 CareFirst Psoriasis Enhanced SGM 4179-A, Stelara-and biosimilars SGM 2010-A – 11/2025.

Psoriasis Enhanced SGM 4179-A Criteria Questions:

1. What is the patient's age? Indicate in years.
❒ 18 years of age or older _____ years, *Continue to 2*
❒ Less than 18 years of age _____ years, *Skip to Stelara and Biosimilars SGM 2010-A Criteria Question 1*

2. What is the diagnosis?
❒ Plaque psoriasis, *Continue to 3*
❒ Plaque psoriasis with co-existing psoriatic arthritis, *Skip to Stelara and Biosimilars SGM 2010-A Criteria Question 1*
❒ Other, please specify: _____, *Skip to Stelara and Biosimilars SGM 2010-A Criteria Question 1*

3. Is the request for Sotyktu?
❒ Yes, *Continue to 4*
❒ No, *Continue to 5*

4. Will the requested drug be used in combination with any other biologic (e.g., Humira) or targeted synthetic drug (e.g., Otezla)?
❒ Yes, *Continue to 7*
❒ No, *Continue to 7*

5. Will the requested drug be used in combination with any other biologic (e.g., Humira) or targeted synthetic drug (e.g., Otezla, Sotyktu) for the same indication?
❒ Yes, *Continue to 6*
❒ No, *Continue to 6*

6. What is the requested medication?
❒ Otezla/Otezla XR, *Continue to 11*
❒ Other, please specify: _____, *Continue to 7*

7. Has the patient ever received (including current utilizers) a biologic (e.g., Humira) or targeted synthetic drug (e.g., Olumiant, Xeljanz) associated with an increased risk of tuberculosis?
❒ Yes, *Continue to 12*
❒ No, *Continue to 8*

8. Has the patient had a tuberculosis (TB) test (e.g., tuberculosis skin test [TST], interferon-release assay [IGRA]) within 12 months of initiating therapy?
❒ Yes, *Continue to 9*
❒ No, *Continue to 11*

9. What were the results of the TB test?
❒ Positive for TB, *Continue to 10*
❒ Negative for TB, *Continue to 12*
❒ Unknown, *Continue to 11*

10. Which of the following applies to the patient?
❒ Patient has latent TB and treatment for latent TB has been initiated, *Continue to 12*
❒ Patient has latent TB and treatment for latent TB has been completed, *Continue to 12*
❒ Patient has latent TB and treatment for latent TB has not been initiated, *Continue to 12*
❒ Patient has active TB, *Continue to 12*

11. What is the severity of the disease?

❒ Mild plaque psoriasis, *Skip to Stelara and Biosimilars SGM 2010-A Criteria Question 1*
❒ Moderate plaque psoriasis, *Continue to 13*
❒ Severe plaque psoriasis, *Continue to 13*

12. Has the patient been diagnosed with moderate to severe plaque psoriasis?
❒ Yes, *Continue to 13*
❒ No, *Continue to 13*

13. Is the requested drug prescribed by or in consultation with a dermatologist?
❒ Yes, *Continue to 14*
❒ No, *Continue to 14*

14. Is this request for continuation of therapy with the requested drug or a biosimilar of the requested drug (if applicable)?
❒ Yes, *Continue to 15*
❒ No, *Continue to 21*

15. Is the patient currently receiving the requested drug or a biosimilar of the requested drug (if applicable) through samples or a manufacturer's patient assistance program?
❒ Yes, *Continue to 21*
❒ No, *Continue to 16*
❒ Unknown, *Continue to 21*

16. Has the patient achieved or maintained a positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition since starting treatment with the requested drug or a biosimilar of the requested drug?
❒ Yes, *Continue to 17*
❒ No, *Continue to 17*

17. What is the patient's current psoriasis involvement in body surface area (BSA) percent? Indicate in percentage. ***ACTION REQUIRED***: Attach supporting chart note(s) or medical record documentation for current psoriasis involvement of BSA percent.
❒ Less than or equal to 3% _____% ***ACTION REQUIRED***: Submit supporting documentation, *Skip to Stelara and Biosimilars SGM 2010-A Criteria Question 58*
❒ Greater than 3% _____% ***ACTION REQUIRED***: Submit supporting documentation. *Continue to 18*

18. What is the patient's percent improvement in body surface area (BSA) from baseline? Indicate in percentage. ***ACTION REQUIRED***: Attach supporting chart note(s) or medical record documentation for percent improvement of BSA from baseline.
❒ Less than 75% BSA improvement _____% ***ACTION REQUIRED***: Submit supporting documentation, *Continue to 19*
❒ Greater than or equal to 75% BSA improvement _____% ***ACTION REQUIRED***: Submit supporting documentation, *Skip to Stelara and Biosimilars SGM 2010-A Criteria Question 58*

19. What is the patient's percent reduction in the Psoriasis Area Severity Index (PASI) score from baseline? Indicate score reduction in percentage. ***ACTION REQUIRED***: Attach supporting chart note(s) or medical record documentation for percent reduction of PASI score from baseline.
❒ Greater than or equal to 75% reduction _____% ***ACTION REQUIRED***: Submit supporting documentation, *Skip to Stelara and Biosimilars SGM 2010-A Criteria Question 58*
❒ Greater than or equal to 50% and less than 75% reduction _____% ***ACTION REQUIRED***:

Submit supporting documentation, *Continue to 20*
❒ Less than 50% reduction _____%, *Continue to 20*

20. What is the patient's Dermatology Life Quality Index (DLQI) score? Indicate patient's DLQI score. ***ACTION REQUIRED***: Attach supporting chart note(s) or medical record documentation for Dermatology Life Quality Index (DLQI) score.
❒ Less than or equal to 5 _____ ***ACTION REQUIRED***: Submit supporting documentation, *Skip to Stelara and Biosimilars SGM 2010-A Criteria Question 58*
❒ Greater than 5 _____, *No further questions*

21. Has the patient received or is currently receiving a biologic (e.g., Humira) or targeted synthetic drug (e.g., Sotyktu, Otezla) within the past 120 days indicated for the treatment of moderate to severe plaque psoriasis (excluding receiving the drug via samples or a manufacturer's patient assistance program)? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried.
❒ Yes, *Skip to Stelara and Biosimilars SGM 2010-A Criteria Question 58*
❒ No, *Continue to 22*

22. Is the percentage of body surface area (BSA) affected (prior to starting the requested medication) less than 3%?
❒ Yes, *Continue to 25*
❒ No, *Continue to 23*

23. What is the percentage of body surface area (BSA) affected (prior to starting the requested medication)? Indicate in percentage. ***ACTION REQUIRED***: Attach supporting chart notes or medical record documentation of body surface area (BSA) affected.
❒ Greater than or equal to 3% but less than 10% _____% ***ACTION REQUIRED***: Submit supporting documentation, *Continue to 24*
❒ Greater than or equal to 10% _____% ***ACTION REQUIRED***: Submit supporting documentation, *Continue to 33*

24. What is the patient's Psoriasis Area Severity Index (PASI) score? Indicate patient's PASI score. ***ACTION REQUIRED***: Attach supporting chart note(s) or medical record documentation of Psoriasis Area Severity Index (PASI) score.
❒ Greater than or equal to 10 _____ ***ACTION REQUIRED***: Submit supporting documentation, *Continue to 26*
❒ Less than 10 _____ ***ACTION REQUIRED***: Submit supporting documentation, *Continue to 25*

25. Is the affected area severe at localized sites and associated with significant functional impairment and/or high levels of distress (e.g., nail disease or involvement of high-impact and difficult-to-treat sites such as face, scalp, palms, soles, flexures and genitals)? ***ACTION REQUIRED***: If Yes, please attach supporting chart notes or medical record documentation of affected area(s) with significant functional impairment and/or high levels of distress.
❒ Yes, *Continue to 33*
❒ No, *Continue to 33*

26. Has the patient had an inadequate response at the maximum tolerated dose to a medium to super-high potency topical corticosteroid therapy for a duration of at least 4 weeks? ***ACTION REQUIRED***: If Yes, please attach supporting chart notes, medical record documentation, or claims history of all prior and current use of treatment regimens for topical corticosteroid therapy, including dosage, duration, and response to therapy.
❒ Yes, *Continue to 33*
❒ No, *Continue to 27*

27. Has the patient had an inadequate response at the maximum tolerated dose to a topical calcineurin inhibitor therapy for a duration of at least 8 weeks? ***ACTION REQUIRED***: If Yes, please attach supporting chart note(s), medical record documentation, or claims history of all prior and current use of treatment regimens for topical calcineurin inhibitor therapy, including dosage, duration, and response to therapy.
❒ Yes, *Continue to 33*
❒ No, *Continue to 28*

28. Has the patient had an inadequate response at the maximum tolerated dose to a topical vitamin D analog therapy for a duration of at least 12 weeks? ***ACTION REQUIRED***: If Yes, please attach supporting chart note(s), medical record documentation, or claims history of all prior and current use of treatment regimens for topical vitamin D analog therapy, including dosage, duration, and response to therapy.
❒ Yes, *Continue to 33*
❒ No, *Continue to 29*

29. Has the patient had an inadequate response at the maximum tolerated dose to a topical retinoid therapy for a duration of at least 12 weeks? ***ACTION REQUIRED***: If Yes, please attach supporting chart note(s), medical record documentation, or claims history of all prior and current use of treatment regimens for topical retinoid therapy, including dosage, duration, and response to therapy.
❒ Yes, *Continue to 33*
❒ No, *Continue to 30*

30. Has the patient had an inadequate response at the maximum tolerated dose to a topical aryl hydrocarbon receptor agonist therapy for a duration of at least 12 weeks? ***ACTION REQUIRED***: If Yes, please attach supporting chart note(s), medical record documentation, or claims history of all prior and current use of treatment regimens for topical aryl hydrocarbon receptor agonist therapy, including dosage, duration, and response to therapy.
❒ Yes, *Continue to 33*
❒ No, *Continue to 31*

31. Has the patient had an inadequate response at the maximum tolerated dose to a topical phosphodiesterase 4 inhibitor therapy for a duration of at least 8 weeks? ***ACTION REQUIRED***: If Yes, please attach supporting chart note(s), medical record documentation, or claims history of all prior and current use of treatment regimens for topical phosphodiesterase 4 inhibitor therapy, including dosage, duration, and response to therapy.
❒ Yes, *Continue to 33*
❒ No, *Continue to 32*

32. Are crucial body areas (e.g., hands, feet, face, neck, scalp, genitals/groin, intertriginous areas) affected? ***ACTION REQUIRED***: If yes, please attach chart notes or medical record documentation of affected areas.
❒ Yes, *Continue to 33*
❒ No, *Continue to 33*

33. Has the patient had a trial of phototherapy (e.g., UVB, PUVA) for a duration of at least 3 months? ***ACTION REQUIRED***: If Yes, please attach supporting chart note(s) or medical record documentation for phototherapy, including dosage, duration, and response to therapy.
❒ Yes, *Continue to 35*
❒ No, *Continue to 34*

34. Does the patient meet any of the following criteria: a) the patient has experienced an intolerable adverse event with phototherapy, b) the patient has a clinical reason to avoid phototherapy, or c) the patient does not have access to phototherapy? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous treatments tried (if applicable), including duration and response to therapy. If therapy is not advisable, please attach documentation of clinical reason to avoid therapy.

❒ Yes, intolerable adverse event to phototherapy ***ACTION REQUIRED***: Submit supporting documentation, *Continue to 35*
❒ Yes, clinical reason to avoid phototherapy ***ACTION REQUIRED***: Submit supporting documentation, *Continue to 35*
❒ Yes, does not have access to phototherapy ***ACTION REQUIRED***: Submit supporting documentation, *Continue to 35*
❒ None of the above, *Continue to 35*

35. Has the patient had a trial of methotrexate at a dose of at least 25 mg/week or at the maximum tolerated dose for a duration of at least 3 months? ***ACTION REQUIRED***: If Yes, please attach supporting chart note(s), medical record documentation, or claims history of all prior and current use of treatment regimens for methotrexate, including dosage, duration, and response to therapy.
❒ Yes, *Skip to Stelara and Biosimilars SGM 2010-A Criteria Question 58*
❒ No, *Continue to 36*

36. Has the patient had a trial of cyclosporine at a dose of at least 5 mg/kg/day or at the maximum tolerated dose for a duration of at least 6 weeks? ***ACTION REQUIRED***: If Yes, please attach supporting chart note(s), medical record documentation, or claims history of all prior and current use of treatment regimens for cyclosporine, including dosage, duration, and response to therapy.
❒ Yes, *Skip to Stelara and Biosimilars SGM 2010-A Criteria Question 58*
❒ No, *Continue to 37*

37. Has the patient had a trial of acitretin at a dose of at least 50 mg/day or at the maximum tolerated dose for a duration of at least 3 months? ***ACTION REQUIRED***: If Yes, please attach supporting chart note(s), medical record documentation, or claims history of all prior and current use of treatment regimens for acitretin, including dosage, duration, and response to therapy.
❒ Yes, *Skip to Stelara and Biosimilars SGM 2010-A Criteria Question 58*
❒ No, *Continue to 38*

38. Does the patient have a clinical reason to avoid systemic pharmacologic treatment with methotrexate, cyclosporine, and acitretin? ***ACTION REQUIRED***: Please attach documentation of clinical reason to avoid therapy.
❒ Yes, *Continue to 39*
❒ No, *Continue to 39*

39. Please indicate the clinical reason to avoid pharmacologic treatment with methotrexate, cyclosporine, and acitretin.
❒ Clinical diagnosis of alcohol use disorder, alcoholic liver disease, or other chronic liver disease, *Skip to Stelara and Biosimilars SGM 2010-A Criteria Question 58*
❒ Drug interaction, *Skip to Stelara and Biosimilars SGM 2010-A Criteria Question 58*
❒ Risk of treatment-related toxicity, *Skip to Stelara and Biosimilars SGM 2010-A Criteria Question 58*
❒ Pregnancy or currently planning pregnancy, *Skip to Stelara and Biosimilars SGM 2010-A Criteria Question 58*
❒ Breastfeeding, *Skip to Stelara and Biosimilars SGM 2010-A Criteria Question 58*
❒ Significant comorbidity prohibits use of systemic agents (e.g., liver or kidney disease, blood dyscrasias, uncontrolled hypertension), *Skip to Stelara and Biosimilars SGM 2010-A Criteria Question 58*
❒ Hypersensitivity, *Skip to Stelara and Biosimilars SGM 2010-A Criteria Question 58*
❒ History of intolerance or adverse event, *Skip to Stelara and Biosimilars SGM 2010-A Criteria Question 58*
❒ Other, please specify. _____, *No Further Questions*

<u>Stelara and Biosimilars SGM 2010-A Criteria Questions:</u>
1. Will the requested drug or a biosimilar of the requested drug be used in combination with any other biologic (e.g., Humira) or targeted synthetic drug (e.g., Otezla, Xeljanz) for the same indication?
❒ Yes, *Continue to 2*
❒ No, *Continue to 2*

2. Has the patient ever received (including current utilizers) a biologic (e.g., Humira) or targeted synthetic drug (e.g., Olumiant, Xeljanz) associated with an increased risk of tuberculosis?
❒ Yes, *Continue to 6*
❒ No, *Continue to 3*

3. Has the patient had a tuberculosis (TB) test (e.g., tuberculosis skin test [TST], interferon-release assay [IGRA]) within 12 months of initiating therapy?
❒ Yes, *Continue to 4*
❒ No, *Continue to 6*

4. What were the results of the tuberculosis (TB) test?
❒ Positive for TB, *Continue to 5*
❒ Negative for TB, *Continue to 6*
❒ Unknown, *Continue to 6*

5. Which of the following applies to the patient?
❒ Patient has latent TB and treatment for latent TB has been initiated, *Continue to 6*
❒ Patient has latent TB and treatment for latent TB has been completed, *Continue to 6*
❒ Patient has latent TB and treatment for latent TB has not been initiated, *Continue to 6*
❒ Patient has active TB, *Continue to 6*

6. What is the diagnosis?
❒ Plaque psoriasis, *Continue to 10*
❒ Psoriatic arthritis WITH co-existent plaque psoriasis, *Continue to 7*
❒ Psoriatic arthritis, *Continue to 25*
❒ Crohn's disease, *Continue to 40*
❒ Ulcerative colitis, *Continue to 46*
❒ Immune checkpoint inhibitor-related diarrhea or colitis, *Continue to 52*
❒ Other, please specify. _____, *No Further Questions*

7. Is the patient 6 years of age or older?
❒ Yes, *Continue to 8*
❒ No, *Continue to 8*

8. Is the requested drug or a biosimilar of the requested drug being prescribed by or in consultation with a rheumatologist or dermatologist?
❒ Yes, *Continue to 9*
❒ No, *Continue to 9*

9. What is the primary diagnosis being treated?
❒ Psoriatic arthritis, *Continue to 27*
❒ Plaque psoriasis, *Continue to 12*

10. Is the patient 6 years of age or older?
❒ Yes, *Continue to 11*
❒ No, *Continue to 11*

11. Is the requested drug or a biosimilar of the requested drug being prescribed by or in consultation with a dermatologist?
❒ Yes, *Continue to 12*

❒ No, *Continue to 12*

12. Has the patient been diagnosed with moderate to severe plaque psoriasis?
❒ Yes, *Continue to 13*
❒ No, *Continue to 13*

13. Is this request for continuation of therapy with the requested drug or a biosimilar of the requested drug?
❒ Yes, *Continue to 14*
❒ No, *Continue to 18*

14. Is the patient currently receiving the requested drug or a biosimilar of the requested drug through samples or a manufacturer's patient assistance program?
❒ Yes, *Continue to 18*
❒ No, *Continue to 15*
❒ Unknown, *Continue to 18*

15. Has the patient achieved or maintained a positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition since starting treatment with the requested drug or a biosimilar of the requested drug?
❒ Yes, *Continue to 16*
❒ No, *Continue to 16*

16. Has the patient experienced a reduction in body surface area (BSA) affected from baseline? ***ACTION REQUIRED***: If Yes, please attach chart notes or medical record documentation of decreased body surface area affected.
❒ Yes, *Continue to 57*
❒ No, *Continue to 17*

17. Has the patient experienced an improvement in signs and symptoms of the condition from baseline (e.g., itching, redness, flaking, scaling, burning, cracking, pain)? ***ACTION REQUIRED***: If Yes, please attach chart notes or medical record documentation of improvement in signs and symptoms.
❒ Yes, *Continue to 57*
❒ No, *Continue to 57*

18. Has the patient ever received or is currently receiving a biologic (e.g., Humira) or targeted synthetic drug (e.g., Sotyktu, Otezla) indicated for treatment of moderate to severe plaque psoriasis (excluding receiving the drug via samples or a manufacturer's patient assistance program)? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried.
❒ Yes, *Continue to 57*
❒ No, *Continue to 19*

19. Are crucial body areas (e.g., hands, feet, face, neck, scalp, genitals/groin, intertriginous areas) affected? ***ACTION REQUIRED***: If Yes, please attach chart notes or medical record documentation of affected areas.
❒ Yes, *Continue to 57*
❒ No, *Continue to 20*

20. Is the percentage of body surface area (BSA) affected (prior to starting the requested medication) less than 3%?
❒ Yes, *Continue to 21*
❒ No, *Continue to 21*

21. What is the percentage of body surface area (BSA) affected (prior to starting the requested drug or a biosimilar of the requested drug)? Indicate percentage. ***ACTION REQUIRED***: Please attach chart notes or medical record documentation

of body surface area affected.
❒ Greater than or equal to 3% to less than 10% of BSA _____ % ***ACTION REQUIRED***: Submit supporting documentation, *Continue to 22*
❒ Greater than or equal to 10% of BSA _____ % ***ACTION REQUIRED***: Submit supporting documentation, *Continue to 57*

22. Has the patient had an inadequate response, or has an intolerance to phototherapy (e.g., UVB, PUVA) or pharmacologic treatment with methotrexate, cyclosporine, or acitretin? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy.
❒ Yes, *Continue to 57*
❒ No, *Continue to 23*

23. Does the patient have a clinical reason to avoid pharmacologic treatment with methotrexate, cyclosporine, and acitretin? ***ACTION REQUIRED***: If Yes, please attach documentation of clinical reason to avoid each therapy.
❒ Yes, *Continue to 24*
❒ No, *Continue to 24*

24. Please indicate the clinical reason to avoid pharmacologic treatment with methotrexate, cyclosporine, and acitretin.
❒ Clinical diagnosis of alcohol use disorder, alcoholic liver disease, or other chronic liver disease, *Continue to 57*
❒ Drug interaction, *Continue to 57*
❒ Risk of treatment-related toxicity, *Continue to 57*
❒ Pregnancy or currently planning pregnancy, *Continue to 57*
❒ Breastfeeding, *Continue to 57*
❒ Significant comorbidity prohibits use of systemic agents (e.g., liver or kidney disease, blood dyscrasias, uncontrolled hypertension), *Continue to 57*
❒ Hypersensitivity, *Continue to 57*
❒ History of intolerance or adverse event, *Continue to 57*
❒ Other, please specify _____, *Continue to 57*

25. Is the patient 6 years of age or older?
❒ Yes, *Continue to 26*
❒ No, *Continue to 26*

26. Is the requested drug or a biosimilar of the requested drug being prescribed by or in consultation with a rheumatologist or dermatologist?
❒ Yes, *Continue to 27*
❒ No, *Continue to 27*

27. Is this request for continuation of therapy with the requested drug or a biosimilar of the requested drug?
❒ Yes, *Continue to 28*
❒ No, *Continue to 31*

28. Is the patient currently receiving the requested drug or a biosimilar of the requested drug through samples or a manufacturer's patient assistance program?
❒ Yes, *Continue to 31*
❒ No, *Continue to 29*
❒ Unknown, *Continue to 31*

29. Has the patient achieved or maintained a positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition since starting treatment with the requested drug or a biosimilar of

the requested drug?
❒ Yes, *Continue to 30*
❒ No, *Continue to 30*

30. Which of the following has the patient experienced an improvement in from baseline? ***ACTION REQUIRED***: Please attach chart notes or medical record documentation supporting positive clinical response.
❒ Number of swollen joints ***ACTION REQUIRED***: Submit supporting documentation, *Continue to 57*
❒ Number of tender joints ***ACTION REQUIRED***: Submit supporting documentation, *Continue to 57*
❒ Dactylitis ***ACTION REQUIRED***: Submit supporting documentation, *Continue to 57*
❒ Enthesitis ***ACTION REQUIRED***: Submit supporting documentation, *Continue to 57*
❒ Skin and/or nail involvement ***ACTION REQUIRED***: Submit supporting documentation, *Continue to 57*
❒ Functional status ***ACTION REQUIRED***: Submit supporting documentation, *Continue to 57*
❒ C-reactive protein (CRP) ***ACTION REQUIRED***: Submit supporting documentation, *Continue to 57*
❒ None of the above, *Continue to 57*

31. Has the patient been diagnosed with active psoriatic arthritis (PsA)?
❒ Yes, *Continue to 32*
❒ No, *Continue to 32*

32. Has the patient ever received or is currently receiving a biologic (e.g., Humira) or targeted synthetic drug (e.g., Rinvoq, Otezla) indicated for active psoriatic arthritis (excluding receiving the drug via samples or a manufacturer's patient assistance program)? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried.
❒ Yes, *Continue to 57*
❒ No, *Continue to 33*

33. What is the patient's disease severity?
❒ Mild to moderate, *Continue to 34*
❒ Severe, *Continue to 57*

34. Does the patient have enthesitis?
❒ Yes, *Continue to 57*
❒ No, *Continue to 35*

35. Has the patient had an inadequate response to methotrexate, leflunomide, or another conventional synthetic drug (e.g., sulfasalazine) administered at an adequate dose and duration? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy.
❒ Yes, *Continue to 57*
❒ No, *Continue to 36*

36. Has the patient had an intolerance to methotrexate, leflunomide, or another conventional synthetic drug (e.g., sulfasalazine)? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy.
❒ Yes, *Continue to 57*
❒ No, *Continue to 37*

37. Does the patient have a contraindication to methotrexate or leflunomide? ***ACTION REQUIRED***: If Yes, please attach documentation of clinical reason to avoid therapy.
❒ Yes, *Continue to 38*
❒ No, *Continue to 39*

38. Please indicate the contraindication to methotrexate or leflunomide.
❒ Clinical diagnosis of alcohol use disorder, alcoholic liver disease, or other chronic liver disease, *Continue to 57*
❒ Drug interaction, *Continue to 57*
❒ Risk of treatment-related toxicity, *Continue to 57*
❒ Pregnancy or currently planning pregnancy, *Continue to 57*
❒ Breastfeeding, *Continue to 57*
❒ Significant comorbidity prohibits use of systemic agents (e.g., liver or kidney disease, blood dyscrasias, uncontrolled hypertension), *Continue to 57*
❒ Hypersensitivity, *Continue to 57*
❒ History of intolerance or adverse event, *Continue to 57*
❒ Other, please specify. _____, *Continue to 57*

39. Does the patient have a contraindication to another conventional synthetic drug (e.g., sulfasalazine)? ***ACTION REQUIRED***: If Yes, please attach documentation of clinical reason to avoid therapy.
❒ Yes, *Continue to 57*
❒ No, *Continue to 57*

40. Has the patient been diagnosed with moderately to severely active Crohn's disease (CD)?
❒ Yes, *Continue to 41*
❒ No, *Continue to 41*

41. Is the requested drug or a biosimilar of the requested drug being prescribed by or in consultation with a gastroenterologist?
❒ Yes, *Continue to 42*
❒ No, *Continue to 42*

42. Which of the following applies to this request for the requested drug or a biosimilar of the requested drug?
❒ Initiation of the intravenous (IV) loading dose, *Continue to 57*
❒ Initiation of the subcutaneous (SQ) maintenance dose, *Continue to 57*
❒ Continuation of the subcutaneous (SQ) maintenance dose, *Continue to 43*

43. Has the patient achieved or maintained remission OR achieved or maintained a positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition since starting treatment with the requested drug or a biosimilar of the requested drug? ***ACTION REQUIRED***: If Yes, please attach chart notes or medical record documentation of remission.
❒ Yes, achieved or maintained remission ***ACTION REQUIRED***: Submit supporting documentation, *Continue to 57*
❒ Yes, achieved or maintained a positive clinical response, *Continue to 44*
❒ No or none of the above, *Continue to 45*

44. Which of the following has the patient experienced an improvement in from baseline? ***ACTION REQUIRED***: Please attach chart notes or medical record documentation supporting positive clinical response to therapy.
❒ Abdominal pain or tenderness ***ACTION REQUIRED***: Submit supporting documentation, *Continue to 57*
❒ Diarrhea ***ACTION REQUIRED***: Submit supporting documentation, *Continue to 57*
❒ Body weight ***ACTION REQUIRED***: Submit supporting documentation, *Continue to 57*
❒ Abdominal mass ***ACTION REQUIRED***: Submit supporting documentation, *Continue to 57*
❒ Hematocrit ***ACTION REQUIRED***: Submit supporting documentation, *Continue to 57*
❒ Appearance of the mucosa on endoscopy, computed tomography enterography (CTE), magnetic resonance enterography (MRE), or intestinal ultrasound ***ACTION REQUIRED***: Submit supporting documentation, *Continue to 57*
❒ Improvement on a disease activity scoring tool (e.g., Crohn's Disease Activity Index [CDAI] score) ***ACTION REQUIRED***: Submit supporting documentation, *Continue to 57*

❒ None of the above, *Continue to 45*

45. Is this a request for an increase in dosing frequency due to the patient not achieving an adequate clinical response at the current frequency?
❒ Yes, *Continue to 57*
❒ No, *Continue to 57*

46. Has the patient been diagnosed with moderately to severely active ulcerative colitis (UC)?
❒ Yes, *Continue to 47*
❒ No, *Continue to 47*

47. Is the requested drug or a biosimilar of the requested drug being prescribed by or in consultation with a gastroenterologist?
❒ Yes, *Continue to 48*
❒ No, *Continue to 48*

48. Which of the following applies to this request for the requested drug or a biosimilar of the requested drug?
❒ Initiation of the intravenous (IV) loading dose, *Continue to 57*
❒ Initiation of the subcutaneous (SQ) maintenance dose, *Continue to 57*
❒ Continuation of the subcutaneous (SQ) maintenance dose, *Continue to 49*

49. Has the patient achieved or maintained remission OR achieved or maintained a positive clinical response to treatment as evidenced by low disease activity or improvement in signs and symptoms of the condition since starting treatment with the requested drug or a biosimilar of the requested drug? ***ACTION REQUIRED***: If Yes, please attach chart notes or medical record documentation of remission.
❒ Yes, achieved or maintained remission ***ACTION REQUIRED***: Submit supporting documentation, *Continue to 57*
❒ Yes, achieved or maintained a positive clinical response, *Continue to 50*
❒ No or none of the above, *Continue to 51*

50. Which of the following has the patient experienced an improvement in from baseline? ***ACTION REQUIRED***: Please attach chart notes or medical record documentation supporting positive clinical response to therapy.
❒ Stool frequency ***ACTION REQUIRED***: Submit supporting documentation, *Continue to 57*
❒ Rectal bleeding ***ACTION REQUIRED***: Submit supporting documentation, *Continue to 57*
❒ Urgency of defecation ***ACTION REQUIRED***: Submit supporting documentation, *Continue to 57*
❒ C-reactive protein (CRP) ***ACTION REQUIRED***: Submit supporting documentation, *Continue to 57*
❒ Fecal calprotectin (FC) ***ACTION REQUIRED***: Submit supporting documentation, *Continue to 57*
❒ Appearance of the mucosa on endoscopy, computed tomography enterography (CTE), magnetic resonance enterography (MRE), or intestinal ultrasound ***ACTION REQUIRED***: Submit supporting documentation, *Continue to 57*
❒ Improvement on a disease activity scoring tool (e.g., Ulcerative Colitis Endoscopic Index of Severity [UCEIS], Mayo Score) ***ACTION REQUIRED***: Submit supporting documentation, *Continue to 57*
❒ None of the above, *Continue to 51*

51. Is this a request for an increase in dosing frequency due to the patient not achieving an adequate clinical response at the current frequency?
❒ Yes, *Continue to 57*
❒ No, *Continue to 57*

52. Is the requested drug or a biosimilar of the requested drug being prescribed by or in consultation with a gastroenterologist, hematologist, or oncologist?
❒ Yes, *Continue to 53*
❒ No, *Continue to 53*

53. Has the patient experienced an inadequate response to infliximab or vedolizumab? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy.
❒ Yes, *Continue to 56*
❒ No, *Continue to 54*

54. Has the patient experienced an intolerance to infliximab or vedolizumab? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy.
❒ Yes, *Continue to 56*
❒ No, *Continue to 55*

55. Does the patient have a contraindication to infliximab or vedolizumab? ***ACTION REQUIRED***: If Yes, please attach documentation of clinical reason to avoid therapy.
❒ Yes, *Continue to 56*
❒ No, *Continue to 56*

56. Is the requested quantity supported by dosing guidelines found in the compendia or current literature (e.g., Micromedex DrugDex, NCCN compendia, current treatment guidelines)?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

57. What is the diagnosis?
❒ Plaque psoriasis, *Continue to 58*
❒ Psoriatic arthritis WITH co-existent plaque psoriasis, *Continue to 58*
❒ Psoriatic arthritis, *Continue to 74*
❒ Crohn's disease, *Continue to 82*
❒ Ulcerative colitis, *Continue to 82*

58. What is the requested formulation?
❒ Subcutaneous injection, *Continue to 59*
❒ Intravenous infusion, *Continue to 59*

59. Is the patient currently receiving the requested drug or a biosimilar of the requested drug?
❒ Yes, *Continue to 60*
❒ No, *Continue to 67*

60. What is the patient's weight? Indicate in kilograms (kg).
❒ Less than or equal to 100 kg _____kg, *Continue to 61*
❒ Greater than 100 kg _____kg, *Continue to 64*

61. Does the prescribed maintenance dose exceed 45 mg?
❒ Yes, *Continue to 62*
❒ No, *Continue to 62*

62. Is the prescribed frequency for the maintenance dose more frequent than one dose every 12 weeks?
❒ Yes, *Continue to 63*
❒ No, *Continue to 63*

63. What is the requested product?

❒ Stelara, *No Further Questions*
❒ Imuldosa, *No Further Questions*
❒ Otulfi, *No Further Questions*
❒ Pyzchiva, *No Further Questions*
❒ Selarsdi, *No Further Questions*
❒ Starjemza, *No Further Questions*
❒ Steqeyma, *No Further Questions*
❒ Ustekinumab, *No Further Questions*
❒ ustekinumab-aauz, *No Further Questions*
❒ ustekinumab-aekn, *No Further Questions*
❒ ustekinumab-stba, *No Further Questions*
❒ ustekinumab-ttwe, *No Further Questions*
❒ Wezlana, *No Further Questions*
❒ Yesintek, *No Further Questions*

64. Does the prescribed maintenance dose exceed 90 mg?
❒ Yes, *Continue to 65*
❒ No, *Continue to 65*

65. Is the prescribed frequency for the maintenance dose more frequent than one dose every 12 weeks?
❒ Yes, *Continue to 66*
❒ No, *Continue to 66*

66. What is the requested product?
❒ Stelara, *No Further Questions*
❒ Imuldosa, *No Further Questions*
❒ Otulfi, *No Further Questions*
❒ Pyzchiva, *No Further Questions*
❒ Selarsdi, *No Further Questions*
❒ Starjemza, *No Further Questions*
❒ Steqeyma, *No Further Questions*
❒ Ustekinumab, *No Further Questions*
❒ ustekinumab-aauz, *No Further Questions*
❒ ustekinumab-aekn, *No Further Questions*
❒ ustekinumab-stba, *No Further Questions*
❒ ustekinumab-ttwe, *No Further Questions*
❒ Wezlana, *No Further Questions*
❒ Yesintek, *No Further Questions*

67. What is the patient's weight? Indicate in kilograms (kg).
❒ Less than or equal to 100 kg _____kg, *Continue to 68*
❒ Greater than 100 kg _____kg, *Continue to 71*

68. Does the prescribed dose exceed a loading dose of 45 mg at weeks 0 and 4, and a maintenance dose of 45 mg thereafter?
❒ Yes, *Continue to 69*
❒ No, *Continue to 69*

69. Is the prescribed frequency for the maintenance dose more frequent than one dose every 12 weeks?
❒ Yes, *Continue to 70*
❒ No, *Continue to 70*

70. What is the requested product?
❒ Stelara, *No Further Questions*
❒ Imuldosa, *No Further Questions*
❒ Otulfi, *No Further Questions*
❒ Pyzchiva, *No Further Questions*
❒ Selarsdi, *No Further Questions*
❒ Starjemza, *No Further Questions*
❒ Steqeyma, *No Further Questions*
❒ Ustekinumab, *No Further Questions*
❒ ustekinumab-aauz, *No Further Questions*
❒ ustekinumab-aekn, *No Further Questions*
❒ ustekinumab-stba, *No Further Questions*
❒ ustekinumab-ttwe, *No Further Questions*
❒ Wezlana, *No Further Questions*
❒ Yesintek, *No Further Questions*

71. Does the prescribed dose exceed a loading dose of 90 mg at weeks 0 and 4, and a maintenance dose of 90 mg thereafter?
❒ Yes, *Continue to 72*
❒ No, *Continue to 72*

72. Is the prescribed frequency for the maintenance dose more frequent than one dose every 12 weeks?
❒ Yes, *Continue to 73*
❒ No, *Continue to 73*

73. What is the requested product?
❒ Stelara, *No Further Questions*
❒ Imuldosa, *No Further Questions*
❒ Otulfi, *No Further Questions*
❒ Pyzchiva, *No Further Questions*
❒ Selarsdi, *No Further Questions*
❒ Starjemza, *No Further Questions*
❒ Steqeyma, *No Further Questions*
❒ Ustekinumab, *No Further Questions*
❒ ustekinumab-aauz, *No Further Questions*
❒ ustekinumab-aekn, *No Further Questions*
❒ ustekinumab-stba, *No Further Questions*
❒ ustekinumab-ttwe, *No Further Questions*
❒ Wezlana, *No Further Questions*
❒ Yesintek, *No Further Questions*

74. What is the requested formulation?
❒ Subcutaneous injection, *Continue to 75*
❒ Intravenous infusion, *Continue to 75*

75. Is the patient currently receiving the requested drug or a biosimilar of the requested drug?
❒ Yes, *Continue to 76*
❒ No, *Continue to 79*

76. Does the prescribed maintenance dose exceed 45 mg?

❒ Yes, *Continue to 77*
❒ No, *Continue to 77*

77. Is the prescribed frequency for the maintenance dose more frequent than one dose every 12 weeks?
❒ Yes, *Continue to 78*
❒ No, *Continue to 78*

78. What is the requested product?
❒ Stelara, *No Further Questions*
❒ Imuldosa, *No Further Questions*
❒ Otulfi, *No Further Questions*
❒ Pyzchiva, *No Further Questions*
❒ Selarsdi, *No Further Questions*
❒ Starjemza, *No Further Questions*
❒ Steqeyma, *No Further Questions*
❒ Ustekinumab, *No Further Questions*
❒ ustekinumab-aauz, *No Further Questions*
❒ ustekinumab-aekn, *No Further Questions*
❒ ustekinumab-stba, *No Further Questions*
❒ ustekinumab-ttwe, *No Further Questions*
❒ Wezlana, *No Further Questions*
❒ Yesintek, *No Further Questions*

79. Does the prescribed dose exceed a loading dose of 45 mg at weeks 0 and 4, and a maintenance dose of 45 mg thereafter?
❒ Yes, *Continue to 80*
❒ No, *Continue to 80*

80. Is the prescribed frequency for the maintenance dose more frequent than one dose every 12 weeks?
❒ Yes, *Continue to 81*
❒ No, *Continue to 81*

81. What is the requested product?
❒ Stelara, *No Further Questions*
❒ Imuldosa, *No Further Questions*
❒ Otulfi, *No Further Questions*
❒ Pyzchiva, *No Further Questions*
❒ Selarsdi, *No Further Questions*
❒ Starjemza, *No Further Questions*
❒ Steqeyma, *No Further Questions*
❒ Ustekinumab, *No Further Questions*
❒ ustekinumab-aauz, *No Further Questions*
❒ ustekinumab-aekn, *No Further Questions*
❒ ustekinumab-stba, *No Further Questions*
❒ ustekinumab-ttwe, *No Further Questions*
❒ Wezlana, *No Further Questions*
❒ Yesintek, *No Further Questions*

82. Which of the following applies to this request for the requested drug or a biosimilar of the requested drug?
❒ Initiation of the intravenous (IV) loading dose, *Continue to 92*
❒ Initiation of the subcutaneous (SQ) maintenance dose, *Continue to 83*

❒ Continuation of the subcutaneous (SQ) maintenance dose, *Continue to 85*

83. Does the prescribed maintenance dose exceed 90 mg?
❒ Yes, *Continue to 84*
❒ No, *Continue to 84*

84. Is the prescribed frequency for the maintenance dose more frequent than one dose every 8 weeks?
❒ Yes, *Continue to 91*
❒ No, *Continue to 91*

85. Does the prescribed maintenance dose exceed 90 mg?
❒ Yes, *Continue to 86*
❒ No, *Continue to 86*

86. Is the prescribed frequency for the maintenance dose more frequent than one dose every 8 weeks?
❒ Yes, *Continue to 87*
❒ No, *Continue to 91*

87. Please select the situation that applies to the patient.
❒ Patient is continuing therapy at current frequency, *Continue to 89*
❒ Prescriber is increasing frequency, *Continue to 88*

88. Does the patient require an increase in dosing frequency due to lack of clinical response at the current dose?
❒ Yes, *Continue to 89*
❒ No, *Continue to 89*

89. Is the prescribed frequency for the maintenance dose more frequent than one dose every 4 weeks?
❒ Yes, *Continue to 90*
❒ No, *Continue to 90*

90. What is the requested product?
❒ Stelara, *No Further Questions*
❒ Imuldosa, *No Further Questions*
❒ Otulfi, *No Further Questions*
❒ Pyzchiva, *No Further Questions*
❒ Selarsdi, *No Further Questions*
❒ Starjemza, *No Further Questions*
❒ Steqeyma, *No Further Questions*
❒ Ustekinumab, *No Further Questions*
❒ ustekinumab-aauz, *No Further Questions*
❒ ustekinumab-aekn, *No Further Questions*
❒ ustekinumab-stba, *No Further Questions*
❒ ustekinumab-ttwe, *No Further Questions*
❒ Wezlana, *No Further Questions*
❒ Yesintek, *No Further Questions*

91. What is the requested product?
❒ Stelara, *No Further Questions*
❒ Imuldosa, *No Further Questions*
❒ Otulfi, *No Further Questions*
❒ Pyzchiva, *No Further Questions*

❒ Selarsdi, *No Further Questions*
❒ Starjemza, *No Further Questions*
❒ Steqeyma, *No Further Questions*
❒ Ustekinumab, *No Further Questions*
❒ ustekinumab-aauz, *No Further Questions*
❒ ustekinumab-aekn, *No Further Questions*
❒ ustekinumab-stba, *No Further Questions*
❒ ustekinumab-ttwe, *No Further Questions*
❒ Wezlana, *No Further Questions*
❒ Yesintek, *No Further Questions*

92. What is the patient's weight? Indicate in kilograms (kg).
❒ Less than or equal to 55 kg _____kg, *Continue to 93*
❒ Greater than 55 kg to less than or equal to 85 kg _____kg, *Continue to 96*
❒ Greater than 85 kg _____kg, *Continue to 99*

93. Does the prescribed dose exceed a one-time loading dose of 260 mg and a maintenance dose of 90 mg thereafter?
❒ Yes, *Continue to 94*
❒ No, *Continue to 94*

94. Is the prescribed frequency for the maintenance dose more frequent than one dose every 8 weeks?
❒ Yes, *Continue to 95*
❒ No, *Continue to 95*

95. What is the requested product?
❒ Stelara, *No Further Questions*
❒ Imuldosa, *No Further Questions*
❒ Otulfi, *No Further Questions*
❒ Pyzchiva, *No Further Questions*
❒ Selarsdi, *No Further Questions*
❒ Starjemza, *No Further Questions*
❒ Steqeyma, *No Further Questions*
❒ Ustekinumab, *No Further Questions*
❒ ustekinumab-aauz, *No Further Questions*
❒ ustekinumab-aekn, *No Further Questions*
❒ ustekinumab-stba, *No Further Questions*
❒ ustekinumab-ttwe, *No Further Questions*
❒ Wezlana, *No Further Questions*
❒ Yesintek, *No Further Questions*

96. Does the prescribed dose exceed a one-time loading dose of 390 mg and a maintenance dose of 90 mg thereafter?
❒ Yes, *Continue to 97*
❒ No, *Continue to 97*

97. Is the prescribed frequency for the maintenance dose more frequent than one dose every 8 weeks?
❒ Yes, *Continue to 98*
❒ No, *Continue to 98*

98. What is the requested product?
❒ Stelara, *No Further Questions*
❒ Imuldosa, *No Further Questions*

❒ Otulfi, *No Further Questions*
❒ Pyzchiva, *No Further Questions*
❒ Selarsdi, *No Further Questions*
❒ Starjemza, *No Further Questions*
❒ Steqeyma, *No Further Questions*
❒ Ustekinumab, *No Further Questions*
❒ ustekinumab-aauz, *No Further Questions*
❒ ustekinumab-aekn, *No Further Questions*
❒ ustekinumab-stba, *No Further Questions*
❒ ustekinumab-ttwe, *No Further Questions*
❒ Wezlana, *No Further Questions*
❒ Yesintek, *No Further Questions*

99. Does the prescribed dose exceed a one-time loading dose of 520 mg and a maintenance dose of 90 mg thereafter?
❒ Yes, *Continue to 100*
❒ No, *Continue to 100*

100. Is the prescribed frequency for the maintenance dose more frequent than one dose every 8 weeks?
❒ Yes, *Continue to 101*
❒ No, *Continue to 101*

101. What is the requested product?
❒ Stelara, *No Further Questions*
❒ Imuldosa, *No Further Questions*
❒ Otulfi, *No Further Questions*
❒ Pyzchiva, *No Further Questions*
❒ Selarsdi, *No Further Questions*
❒ Starjemza, *No Further Questions*
❒ Steqeyma, *No Further Questions*
❒ Ustekinumab, *No Further Questions*
❒ ustekinumab-aauz, *No Further Questions*
❒ ustekinumab-aekn, *No Further Questions*
❒ ustekinumab-stba, *No Further Questions*
❒ ustekinumab-ttwe, *No Further Questions*
❒ Wezlana, *No Further Questions*
❒ Yesintek, *No Further Questions*

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____
Prescriber or Authorized Signature **Date (mm/dd/yy)**