PA Request Criteria

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This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to CVS/Caremark at . Please contact CVS/Caremark at 1-888-413-2723 with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of the medication.

Patient Name: _____ **Date:** 5/13/2025
Patient ID: _____ **Patient Date Of Birth:** _____
Patient Group No: _____ **NPI#:** **Patient Phone:** _____ **Physician Name:**
Specialty:
Physician Office Address: _____ **Physician Office Telephone:**

Drug Name (specify drug) _____
Quantity: _____ **Frequency:** _____ **Strength:** _____
Route of Administration: _____ **Expected Length of Therapy:** _____
Diagnosis: _____ **ICD Code:** _____
Comments: _____

Please check the appropriate answer for each applicable question.

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? **Y** ☐ **N** ☐
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? **Y** ☐ **N** ☐
3. Has the patient had a tuberculosis (TB) test (e.g., tuberculosis skin test [TST], interferonrelease assay [IGRA]) within 12 months of initiating therapy? **Y** ☐ **N** ☐
4. What were the results of the tuberculosis (TB) test? Positive for TB (If checked, go to 5) ☐

   Negative for TB (If checked, go to 6) ☐ Unknown (If checked, no further questions) ☐

5. Which of the following applies to the patient?

   Patient has latent TB and treatment for latent TB has been initiated (If checked, go to 6) ☐

   Patient has latent TB and treatment for latent TB has been completed (If checked, go to 6) ☐

   Patient has latent TB and treatment for latent TB has not been initiated (If checked, no further questions) ☐

   Patient has active TB (If checked, no further questions) ☐

6. What is the diagnosis?

   Plaque psoriasis (If checked, go to 10) ☐

   Psoriatic arthritis WITH co-existent plaque psoriasis (If checked, go to 7) ☐

   Psoriatic arthritis (If checked, go to 25) ☐

   Crohn's disease (If checked, go to 40) ☐ ☐

   Ulcerative colitis (If checked, go to 46) ☐

Immune checkpoint inhibitor-related diarrhea or colitis (If checked, go to 52)

Other, please specify. (If checked, no further questions) ☐

_____

7. Is the patient 6 years of age or older? Y ☐ N ☐

8. Is the requested drug or a biosimilar of the requested drug being prescribed by or in consultation with a rheumatologist or dermatologist? Y ☐ N

9. What is the primary diagnosis being treated?

Psoriatic arthritis (If checked, go to 27) ☐

Plaque psoriasis (If checked, go to 12) ☐

10. Is the patient 6 years of age or older? Y ☐ N ☐

11. Is the requested drug or a biosimilar of the requested drug being prescribed by or in consultation with a dermatologist? Y ☐ N ☐

12. Has the patient been diagnosed with moderate to severe plaque psoriasis? Y ☐ N ☐

13. Is this request for continuation of therapy with the requested drug or a biosimilar of the requested drug? Y ☐ N

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 (If checked, go to 18) ☐

No (If checked, go to 15) ☐

Unknown (If checked, go 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? Y ☐ N ☐

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. Y ☐ N

ACTION REQUIRED: Submit supporting documentation ☐

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. Y ☐ N

ACTION REQUIRED: Submit supporting documentation ☐

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. ACTION REQUIRED: Submit supporting documentation Y ☐ N

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. Y ☐ N ☐

ACTION REQUIRED: Submit supporting documentation

20. Is the percentage of body surface area (BSA) affected (prior to starting the requested medication) less than 3%? Y ☐ N ☐

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 (If checked, go to 22) ☐

Greater than or equal to 10% of BSA (If checked, go to 57) ☐

ACTION REQUIRED: Submit supporting documentation

22. Has the patient experienced 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. Y ☐ N ☐
ACTION REQUIRED: Submit supporting documentation

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. Y ☐ N ☐
ACTION REQUIRED: Submit supporting documentation

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 (If checked, go to 57) ☐

Drug interaction (If checked, go to 57) ☐

Risk of treatment-related toxicity (If checked, go to 57) ☐

Pregnancy or currently planning pregnancy (If checked, go to 57) ☐

Breastfeeding (If checked, go to 57) ☐

Significant comorbidity prohibits use of systemic agents (e.g., liver or kidney disease, blood dyscrasias, uncontrolled hypertension) (If checked, go to 57) ☐

Hypersensitivity (If checked, go to 57) ☐

History of intolerance or adverse event (If checked, go to 57) ☐

Other, please specify (If checked, no further questions) ☐

25. Is the patient 6 years of age or older? Y ☐ N ☐

26. Is the requested drug or a biosimilar of the requested drug being prescribed by or in consultation with a rheumatologist or dermatologist? Y ☐ N ☐

27. Is this request for continuation of therapy with the requested drug or a biosimilar of the requested drug? Y ☐ N

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 (If checked, go to 31) ☐

No (If checked, go to 29) ☐

Unknown (If checked, go 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? Y ☐ N ☐

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 (If checked, go to 57) ☐

Number of tender joints (If checked, go to 57) ☐

Dactylitis (If checked, go to 57) ☐

Enthesitis (If checked, go to 57) ☐

Skin and/or nail involvement (If checked, go to 57) ☐

Functional status (If checked, go to 57) ☐

C-reactive protein (CRP) (If checked, go to 57)

None of the above (If checked, no further questions)

ACTION REQUIRED: Submit supporting documentation

31. Has the patient been diagnosed with active psoriatic arthritis (PsA)? **Y** ☐ **N** ☐

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 the treatment of 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. ACTION REQUIRED: Submit supporting documentation **Y** ☐ **N** ☐

33. What is the patient's disease severity?

Mild to moderate (If checked, go to 34) ☐

Severe (If checked, go to 57) ☐

34. Does the patient have enthesitis? **Y** ☐ **N** ☐

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.
ACTION REQUIRED: Submit supporting documentation **Y** ☐ **N** ☐

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.
ACTION REQUIRED: Submit supporting documentation **Y** ☐ **N** ☐

37. Does the patient have a contraindication to methotrexate or leflunomide? ACTION REQUIRED: If Yes, please attach documentation of clinical reason to avoid therapy.
ACTION REQUIRED: Submit supporting documentation **Y** ☐ **N** ☐

38. Please indicate the contraindication to methotrexate or leflunomide.

Clinical diagnosis of alcohol use disorder, alcoholic liver disease, or other chronic liver disease (If checked, go to 57) ☐

Drug interaction (If checked, go to 57) ☐

Risk of treatment-related toxicity (If checked, go to 57) ☐

Pregnancy or currently planning pregnancy (If checked, go to 57) ☐

Breastfeeding (If checked, go to 57) ☐

Significant comorbidity prohibits use of systemic agents (e.g., liver or kidney disease, blood dyscrasias, uncontrolled hypertension) (If checked, go to 57) ☐

Hypersensitivity (If checked, go to 57) ☐

History of intolerance or adverse event (If checked, go to 57) ☐

Other, please specify. (If checked, no further questions) ☐

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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. **Y** ☐ **N** ☐
ACTION REQUIRED: Submit supporting documentation ☐

40. Has the patient been diagnosed with moderately to severely active Crohn's disease (CD)? **Y** ☐ **N** ☐

41. Is the requested drug or a biosimilar of the requested drug being prescribed by or in consultation with a gastroenterologist? **Y** ☐ **N** ☐

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 (If checked, go to 57) ☐

Initiation of the subcutaneous (SQ) maintenance dose (If checked, go to 57) ☐

Continuation of the subcutaneous (SQ) maintenance dose (If checked, go to 43) ☐

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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 or positive clinical response to therapy.
Yes, achieved or maintained remission (If checked, go to 57) ☐
Yes, achieved or maintained a positive clinical response (If checked, go to 44) ☐
No or none of the above (If checked, go to 45) ☐
ACTION REQUIRED: Submit supporting documentation

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 (If checked, go to 57) ☐
Diarrhea (If checked, go to 57) ☐
Body weight (If checked, go to 57) ☐
Abdominal mass (If checked, go to 57) ☐
Hematocrit (If checked, go to 57) ☐
Appearance of the mucosa on endoscopy, computed tomography enterography (CTE), magnetic resonance enterography (MRE), or intestinal ultrasound (If checked, go to 57) ☐
Improvement on a disease activity scoring tool (e.g., Crohn's Disease Activity Index [CDAI] score) (If checked, go to 57) ☐
None of the above (If checked, go to 45) ☐
ACTION REQUIRED: Submit supporting documentation ☐

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? **Y** ☐ **N** ☐

46. Has the patient been diagnosed with moderately to severely active ulcerative colitis (UC)? **Y** ☐ **N** ☐

47. Is the requested drug or a biosimilar of the requested drug being prescribed by or in consultation with a gastroenterologist? **Y** ☐ **N** ☐

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 (If checked, go to 57) ☐
Initiation of the subcutaneous (SQ) maintenance dose (If checked, go to 57) ☐
Continuation of the subcutaneous (SQ) maintenance dose (If checked, go 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 or positive clinical response to therapy.
Yes, achieved or maintained remission (If checked, go to 57) ☐
Yes, achieved or maintained a positive clinical response (If checked, go to 50) ☐
No or none of the above (If checked, go to 51) ☐
ACTION REQUIRED: Submit supporting documentation ☐

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 (If checked, go to 57)
- ☐ Rectal bleeding (If checked, go to 57)
- ☐ Urgency of defecation (If checked, go to 57)
- ☐ C-reactive protein (CRP) (If checked, go to 57)
- ☐ Fecal calprotectin (FC) (If checked, go to 57)
- ☐ Appearance of the mucosa on endoscopy, computed tomography enterography (CTE), magnetic resonance enterography (MRE), or intestinal ultrasound (If checked, go to 57)
- ☐ Improvement on a disease activity scoring tool (e.g., Ulcerative Colitis Endoscopic Index of Severity [UCEIS], Mayo Score) (If checked, go to 57)
- ☐ None of the above (If checked, go to 51)

ACTION REQUIRED: Submit supporting documentation

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? **Y** ☐ **N** ☐

52. Is the requested drug or a biosimilar of the requested drug being prescribed by or in consultation with a gastroenterologist, hematologist, or oncologist? **Y** ☐ **N** ☐

53. Has the patient experienced an inadequate response to infliximab or vedolizumab? **Y** ☐ **N** ☐ ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy. ACTION REQUIRED: Submit supporting documentation

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. ACTION REQUIRED: Submit supporting documentation **Y** ☐ **N** ☐

55. Does the patient have a contraindication to infliximab and vedolizumab? ACTION REQUIRED: If Yes, please attach documentation of clinical reason to avoid therapy. ACTION REQUIRED: Submit supporting documentation **Y** ☐ **N** ☐

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)? **Y** ☐ **N** ☐

57. What is the diagnosis?

- ☐ Plaque psoriasis (If checked, go to 58)
- ☐ Psoriatic arthritis WITH co-existent plaque psoriasis (If checked, go to 58)
- ☐ Psoriatic arthritis (If checked, go to 74)
- ☐ Crohn's disease (If checked, go to 82)
- ☐ Ulcerative colitis (If checked, go to 82)

58. What is the requested formulation?

- ☐ Subcutaneous injection (If checked, go to 59)
- ☐ Intravenous infusion (If checked, no further questions)

59. Is the patient currently receiving the requested drug or a biosimilar of the requested drug? **Y** ☐ **N** ☐

60. What is the patient's weight? Indicate in kilograms (kg). ☐

Less than or equal to 100 kg (If checked, go to 61) ☐

_____

Greater than 100 kg (If checked, go to 64) ☐

_____

61. Does the prescribed maintenance dose exceed 45 mg? **Y** ☐ **N**

62. Is the prescribed frequency for the maintenance dose more frequent than one dose every 12 weeks? **Y** ☐ **N**

63. What is the requested product?

Stelara (If checked, no further questions) ☐

Imuldosa (If checked, no further questions) ☐

Otulfi (If checked, no further questions) ☐

Pyzchiva (If checked, no further questions) ☐

Selarsdi (If checked, no further questions) ☐

Steqeyma (If checked, no further questions) ☐

ustekinumab-aekn (If checked, no further questions) ustekinumab-ttwe (If checked, no further questions) ☐

Wezlana (If checked, no further questions) ☐

Yesintek (If checked, no further questions) ☐

64. Does the prescribed maintenance dose exceed 90 mg? **Y** ☐ **N**

65. Is the prescribed frequency for the maintenance dose more frequent than one dose every 12 weeks? **Y** ☐ **N**

66. What is the requested product?

Stelara (If checked, no further questions) ☐

Imuldosa (If checked, no further questions) ☐

Otulfi (If checked, no further questions) ☐

Pyzchiva (If checked, no further questions) ☐

Selarsdi (If checked, no further questions) ☐

Steqeyma (If checked, no further questions) ☐

ustekinumab-aekn (If checked, no further questions) ☐

ustekinumab-ttwe (If checked, no further questions) ☐

Wezlana (If checked, no further questions) ☐

Yesintek (If checked, no further questions) ☐

67. What is the patient's weight? Indicate in kilograms (kg).

Less than or equal to 100 kg (If checked, go to 68) ☐

_____

Greater than 100 kg (If checked, go 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? **Y** ☐ **N** ☐

69. Is the prescribed frequency for the maintenance dose more frequent than one dose every 12 weeks? **Y** ☐ **N** ☐

70. What is the requested product?

- Stelara (If checked, no further questions) ☐
- Imuldosa (If checked, no further questions) ☐
- Otulfi (If checked, no further questions) ☐
- Pyzchiva (If checked, no further questions) ☐
- Selarsdi (If checked, no further questions) ☐
- Steqeyma (If checked, no further questions) ☐
- ustekinumab-aekn (If checked, no further questions) ustekinumab- ☐
- ttwe (If checked, no further questions) ☐
- Wezlana (If checked, no further questions) ☐
- Yesintek (If checked, 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? **Y** ☐ **N** ☐

72. Is the prescribed frequency for the maintenance dose more frequent than one dose every 12 weeks? **Y** ☐ **N** ☐

73. What is the requested product?

- Stelara (If checked, no further questions) ☐
- Imuldosa (If checked, no further questions) ☐
- Otulfi (If checked, no further questions) ☐
- Pyzchiva (If checked, no further questions) ☐
- Selarsdi (If checked, no further questions) ☐
- Steqeyma (If checked, no further questions) ☐
- ustekinumab-aekn (If checked, no further questions) ☐
- ustekinumab-ttwe (If checked, no further questions) ☐
- Wezlana (If checked, no further questions) ☐
- Yesintek (If checked, no further questions) ☐

74. What is the requested formulation?

- Subcutaneous injection (If checked, go to 75) ☐
- Intravenous infusion (If checked, no further questions) ☐

75. Is the patient currently receiving the requested drug or a biosimilar of the requested drug? **Y** ☐ **N** ☐

76. Does the prescribed maintenance dose exceed 45 mg? **Y** ☐ **N** ☐

77. Is the prescribed frequency for the maintenance dose more frequent than one dose every 12 weeks? **Y** ☐ **N** ☐

78. What is the requested product?

☐ ☐

Stelara (If checked, no further questions) ☐

Imuldosa (If checked, no further questions) ☐

Otulfi (If checked, no further questions) ☐

Pyzchiva (If checked, no further questions) ☐

Selarsdi (If checked, no further questions) ☐

Steqeyma (If checked, no further questions) ☐

ustekinumab-aekn (If checked, no further questions) ☐

ustekinumab-ttwe (If checked, no further questions) ☐

Wezlana (If checked, no further questions) ☐

Yesintek (If checked, 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? **Y** ☐ **N** ☐

80. Is the prescribed frequency for the maintenance dose more frequent than one dose every 12 weeks? **Y** ☐ **N** ☐

81. What is the requested product?

- Stelara (If checked, no further questions) ☐
- Imuldosa (If checked, no further questions) ☐
- Otulfi (If checked, no further questions) ☐
- Pyzchiva (If checked, no further questions) ☐
- Selarsdi (If checked, no further questions) ☐
- Steqeyma (If checked, no further questions) ☐
- ustekinumab-aekn (If checked, no further questions) ☐
- ustekinumab-ttwe (If checked, no further questions) ☐
- Wezlana (If checked, no further questions) ☐
- Yesintek (If checked, 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 (If checked, go to 92) ☐
- Initiation of the subcutaneous (SQ) maintenance dose (If checked, go to 83) ☐
- Continuation of the subcutaneous (SQ) maintenance dose (If checked, go to 85) ☐

83. Does the prescribed maintenance dose exceed 90 mg? **Y** ☐ **N** ☐

84. Is the prescribed frequency for the maintenance dose more frequent than one dose every 8 weeks? **Y** ☐ **N** ☐

85. Does the prescribed maintenance dose exceed 90 mg? **Y** ☐ **N** ☐

86. Is the prescribed frequency for the maintenance dose more frequent than one dose every 8 weeks? **Y** ☐ **N**

87. Please select the situation that applies to the patient.

- Patient is continuing therapy at current frequency (If checked, go to 89) ☐
- Prescriber is increasing frequency (If checked, go to 88) ☐

88. Does the patient require an increase in dosing frequency due to lack of clinical response at the current dose? **Y** ☐ **N** ☐

89. Is the prescribed frequency for the maintenance dose more frequent than one dose every 4 weeks? **Y** ☐ **N**

90. What is the requested product?

- Stelara (If checked, no further questions) ☐
- Imuldosa (If checked, no further questions) ☐
- Otulfi (If checked, no further questions) ☐
- Pyzchiva (If checked, no further questions) ☐
- Selarsdi (If checked, no further questions) ☐
- Steqeyma (If checked, no further questions) ☐

ustekinumab-aekn (If checked, no further questions) ☐

ustekinumab-ttwe (If checked, no further questions) ☐

Wezlana (If checked, no further questions) ☐

Yesintek (If checked, no further questions) ☐

91. What is the requested product?

Stelara (If checked, no further questions) ☐

Imuldosa (If checked, no further questions) ☐

Otulfi (If checked, no further questions) ☐

Pyzchiva (If checked, no further questions) ☐

Selarsdi (If checked, no further questions) ☐

Steqeyma (If checked, no further questions) ☐

ustekinumab-aekn (If checked, no further questions) ☐

ustekinumab-ttwe (If checked, no further questions) ☐

Wezlana (If checked, no further questions) ☐

Yesintek (If checked, no further questions) ☐

92. What is the patient's weight? Indicate in kilograms (kg).

Less than or equal to 55 kg (If checked, go to 93) ☐

_____

Greater than 55 kg to less than or equal to 85 kg (If checked, go to 96) ☐

_____

Greater than 85 kg (If checked, go to 99) ☐

_____

93. Does the prescribed dose exceed a one-time loading dose of 260 mg and a maintenance dose of 90 mg thereafter? **Y** ☐ **N**

94. Is the prescribed frequency for the maintenance dose more frequent than one dose every 8 weeks? **Y** ☐ **N**

95. What is the requested product?

Stelara (If checked, no further questions) ☐

Imuldosa (If checked, no further questions) ☐

Otulfi (If checked, no further questions) ☐

Pyzchiva (If checked, no further questions) ☐

Selarsdi (If checked, no further questions) ☐

Steqeyma (If checked, no further questions) ☐

ustekinumab-aekn (If checked, no further questions) ☐

ustekinumab-ttwe (If checked, no further questions) ☐

Wezlana (If checked, no further questions) ☐

Yesintek (If checked, 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? **Y** ☐ **N**

97. Is the prescribed frequency for the maintenance dose more frequent than one dose every 8 weeks? **Y** ☐ **N** ☐

98. What is the requested product?

- Stelara (If checked, no further questions) ☐
- Imuldosa (If checked, no further questions) ☐
- Otulfi (If checked, no further questions) ☐
- Pyzchiva (If checked, no further questions) ☐
- Selarsdi (If checked, no further questions) ☐
- Steqeyma (If checked, no further questions) ☐
- ustekinumab-aekn (If checked, no further questions) ☐
- ustekinumab-ttwe (If checked, no further questions) ☐
- Wezlana (If checked, no further questions) ☐
- Yesintek (If checked, 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? **Y** ☐ **N** ☐

100. Is the prescribed frequency for the maintenance dose more frequent than one dose every 8 weeks? **Y** ☐ **N** ☐

101. What is the requested product?

- Stelara (If checked, no further questions) ☐
- Imuldosa (If checked, no further questions) ☐
- Otulfi (If checked, no further questions) ☐
- Pyzchiva (If checked, no further questions) ☐
- Selarsdi (If checked, no further questions) ☐
- Steqeyma (If checked, no further questions) ☐
- ustekinumab-aekn (If checked, no further questions) ☐
- ustekinumab-ttwe (If checked, no further questions) ☐
- Wezlana (If checked, no further questions) ☐
- Yesintek (If checked, no further questions) ☐

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

_____

Prescriber (Or Authorized) Signature and Date