BlueCross BlueShield Federal Employee Program

STELARA
PRIOR APPROVAL REQUEST

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		

PHYSICIAN COMPLETES

All approved requests for STELARA OR NON-PREFERRED BIOSIMILARS are subject to review by a clinical specialist for final validation and coverage determination once all required documentation has been received. Current utilization, including samples, does not guarantee approval of coverage. SUBMITTING THE PATIENT'S MEDICAL RECORDS IS REQUIRED.

STELARA

NOTE: Form must be completed in its **entirety** for processing

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

1. Please select the requested medication and proceed with answering the questions on the pages indicated below:

❑Pyzchiva (ustekinumab-ttwe) **❑ustekinumab-aauz (generic Otulfi)** **❑Yesintek (ustekinumab-kfce)**

a. Has the patient been on this medication continuously for the last **6 months** excluding samples? ***Please select answer below:***
   - ❑**NO** – this is **INITIATION** of therapy, please answer the questions on **PAGES 2-4**
   - ❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the questions on **PAGE 5-6**

❑Stelara (ustekinumab) **❑Otulfi (BRAND)** **❑Steqeyma (ustekinumab-stba)**
❑Imuldosa (ustekinumab-srlf) **❑Selarsdi (ustekinumab-aekn)** **❑Wezlana (ustekinumab-auub)**

a. Has the patient been on this medication continuously for the last **6 months** excluding samples? ***Please select answer below:***
   - ❑**NO** – this is **INITIATION** of therapy, please answer the questions on **PAGES 7-13**
   - ❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the questions on **PAGE 14-19**

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Fax: 1-877-378-4727

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: R			Physician Signature:		
PHYSICIAN COMPLETES					

INITIATION OF THERAPY

NOTE: Form must be completed in its **entirety** for processing

Please select medication:

❑**Pyzchiva (ustekinumab-ttwe)** ❑ **ustekinumab-aauz (generic Otulfi)** ❑**Yesintek (ustekinumab-kfce)**

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

1. Has the patient been on this medication continuously for the last **6 months** excluding samples? ***Please select answer below:***
   ❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the questions on **PAGE 5**
   ❑**NO –** this is **INITIATION** of therapy, please answer the questions below:
2. Is this request for brand or generic? ❑Brand ❑Generic
3. Has the patient been tested for latent tuberculosis (TB)? ❑Yes* ❑No
   If YES, was the result of the test positive or negative for TB infection? ❑Positive* ❑Negative
   If POSITIVE, has the patient completed treatment or is the patient currently receiving treatment for latent TB? ❑Yes ❑No
4. Does the patient have any active infections including active TB or Hepatitis B Virus infection (HBV)? ❑Yes ❑No
5. Will the patient be given live vaccines while on this therapy? ❑Yes ❑No
6. Will Stelara be used in combination with another biologic *DMARD or targeted synthetic DMARD? ❑Yes* ❑No
   If YES, please specify the medication: _____
   DMARDs: Actemra or an Actemra biosimilar, Avsola, Bimzelx, Cimzia, Cosentyx, Enbrel, Entyvio, Humira or a Humira biosimilar, Ilumya, Inflectra, Kevzara, Kineret, Olumiant, Orencia, Otezla, Remicade, Renflexis, Riabni, Rinvoq, Rituxan, Ruxience, Siliq, Simponi/Simponi Aria, Skyrizi, Sotyktu, Spevigo, Stelara or a Stelara biosimilar, Taltz, Tremfya, Truxima, Xeljanz/Xeljanz XR.
7. What is the patient's diagnosis?
   ❑Crohn's disease (CD)
   a. Does the patient have moderate to severely active Crohn's disease (CD)? ❑Yes ❑No
   b. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to at least one conventional therapy option? ❑Yes ❑No
   c. Will the patient's first dose be given an IV infusion? ❑Yes ❑No
   d. What is the patient's weight in either pounds (lbs) or kilograms (kg)? ***Please select answer below:***
   ❑**55kg (121lbs) or less**: Does the prescriber agree to administer 260mg for the initial IV infusion? ❑Yes ❑No
   ❑**Greater than 55kg (121lbs) to 85kg (187lbs)**: Does the prescriber agree to administer 390mg for the initial IV infusion? ❑Yes ❑No
   ❑**Greater than 85kg (187lbs)**: Does the prescriber agree to administer 520mg for the initial infusion? ❑Yes ❑No
   e. Following the initial IV infusion, does the prescriber agree not to exceed the FDA labeled maintenance dose of 90 mg subcutaneously every 8 weeks? ❑Yes ❑No
   f. Is this medication being requested as a change from Cimzia, Entyvio, Humira or a non-preferred biosimilar, Omvoh, or Stelara or a non-preferred biosimilar? ❑Yes* ❑No
   If YES, please select medication: ❑Cimzia ❑Entyvio ❑Humira or a non-preferred biosimilar ❑Omvoh ❑Stelara or a non-preferred biosimilar

PLEASE PROCEED TO PAGE 3 FOR ADDITIONAL DIAGNOSES

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PAGE 2 - PHYSICIAN COMPLETES

Patient Name: _____ DOB: _____ Patient ID: R _____

❑ Plaque psoriasis (PsO)

a. Does the patient have moderate to severe plaque psoriasis (PsO)? ❑Yes ❑No

b. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to conventional systemic therapy? ***Please select answer below:***

❑ Inadequate treatment response ❑ Intolerance or contraindication ❑ Has not tried conventional systemic therapy

c. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to phototherapy?
Please select answer: ❑ Inadequate treatment response ❑ Intolerance or contraindication ❑ Has not tried phototherapy

d. **Age 6-17**: What is the patient's weight in either pounds (lbs) or kilograms (kg)? ***Please select answer below:***

❑**Less than 60kg (132lbs)**: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 0.75 milligrams per kilogram (mg/kg) subcutaneously every 12 weeks? ❑Yes ❑No

❑**60kg (132lbs) to 100kg (220lbs)**: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 45mg subcutaneously every 12 weeks? ❑Yes ❑No

❑**Greater than 100kg (220lbs):** Does the prescriber agree not to exceed the FDA labeled maintenance dose of 90mg subcutaneously every 12 weeks? ❑Yes ❑No

e. **Age 18 or Older**: What is the patient's weight in either pounds (lbs) or kilograms (kg)? ***Please select answer below:***

❑**Less than or equal to 100kg (220lbs)**: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 45mg subcutaneously every 12 weeks? ❑Yes ❑No

❑**Greater than 100kg (221lbs):** Does the prescriber agree not to exceed the FDA labeled maintenance dose of 90mg subcutaneously every 12 weeks? ❑Yes ❑No

f. Is this medication being requested as a change from Bimzelx, Cimzia, Cosentyx, Humira or a non-preferred biosimilar, Ilumya, Siliq, Sotyktu, or Stelara or a non-preferred biosimilar? ❑Yes***** ❑No

****If YES***, please select medication: ❑Bimzelx ❑Cimzia ❑Cosentyx ❑Humira or a non-preferred biosimilar
❑Ilumya ❑Siliq ❑Sotyktu ❑Stelara or a non-preferred biosimilar

❑ Psoriatic arthritis (PsA)

a. Does the patient have active psoriatic arthritis (PsA)? ❑Yes ❑No

b. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to a 3-month trial of at least one conventional DMARD? ❑Yes ❑No

c. **Age 6-17**: What is the patient's weight in either pounds (lbs) or kilograms (kg)? ***Please select answer below:***

❑**Less than 60kg (132lbs)**: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 0.75 milligrams per kilogram (mg/kg) subcutaneously every 12 weeks? ❑Yes ❑No

❑**60kg (132lbs) to 100kg (220lbs)**: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 45mg subcutaneously every 12 weeks? ❑Yes ❑No

❑**Greater than 100kg (220lbs):** Does the patient have a concurrent diagnosis of moderate to severe plaque psoriasis?

❑**Yes**: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 90 mg subcutaneously every 12 weeks? ❑Yes ❑No

❑**No:** Does the prescriber agree not to exceed the FDA labeled maintenance dose of 45mg subcutaneously every 12 weeks? ❑Yes ❑No

d. **Age 18 or Older**: What is the patient's weight in either pounds (lbs) or kilograms (kg)? ***Please select answer below:***

❑**Less than or equal to 100kg (220lbs)**: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 45mg subcutaneously every 12 weeks? ❑Yes ❑No

❑**Greater than 100kg (220lbs)**: Does the patient have a concurrent diagnosis of moderate to severe plaque psoriasis?

❑**Yes**: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 90 mg subcutaneously every 12 weeks? ❑Yes ❑No

❑**No:** Does the prescriber agree not to exceed the FDA labeled maintenance dose of 45mg subcutaneously every 12 weeks? ❑Yes ❑No

PLEASE PROCEED TO PAGE 4 FOR ADDITIONAL PSORIATIC ARTHRITIS RELATED QUESTIONS & OTHER DIAGNOSES

PAGE 3 - PHYSICIAN COMPLETES

Patient Name: _____ DOB: _____ Patient ID: R _____

Psoriatic arthritis CONTINUED:

e. **Age 18 or older:** Is this medication being requested as a change from Bimzelx, Cimzia, Cosentyx, Humira or a non-preferred biosimilar, Orencia, Simponi, or Stelara or a non-preferred biosimilar? ❑Yes* ❑No

If YES, please select medication: ❑Bimzelx ❑Cimzia ❑Cosentyx ❑Humira or a non-preferred biosimilar ❑Orencia ❑Simponi ❑Stelara or a non-preferred biosimilar

❑ Ulcerative colitis (UC)

a. Does the patient have a diagnosis of moderate to severely active ulcerative colitis (UC)? ❑Yes ❑No

b. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to at least one conventional therapy option? ❑Yes ❑No

c. Will the patient's first dose be given as an IV infusion? ❑Yes ❑No

d. What is the patient's weight in either pounds (lbs) or kilograms (kg)? ***Please select answer below:***

❑**55kg (121lbs) or less**: Does the prescriber agree to administer 260mg for the initial IV infusion? ❑Yes ❑No

❑**Greater than 55kg (121lbs) to 85kg (187lbs)**: Does the prescriber agree to administer 390mg for the initial IV infusion? ❑Yes ❑No

❑**Greater than 85kg (187lbs)**: Does the prescriber agree to administer 520mg for the initial infusion? ❑Yes ❑No

e. Following the initial IV infusion, does the prescriber agree not to exceed the FDA labeled maintenance dose of 90 mg subcutaneously every 8 weeks? ❑Yes ❑No

f. Is this medication being requested as a change from Entyvio, Humira or a non-preferred biosimilar, Omvoh, Simponi, Stelara or a non-preferred biosimilar, Velsipity, or Zeposia? ❑Yes* ❑No

If YES, please select medication: ❑Entyvio ❑Humira or a non-preferred biosimilar ❑Omvoh ❑Simponi ❑Stelara or a non-preferred biosimilar ❑Velsipity ❑Zeposia

❑ Other ***(please specify):*** _____

BlueCross BlueShield Federal Employee Program

STELARA
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Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

CONTINUATION OF THERAPY (PA RENEWAL)

NOTE: Form must be completed in its **entirety** for processing

Please select medication:

❑Pyzchiva (ustekinumab-ttwe) **❑ ustekinumab-aauz (generic Otulfi)** **❑Yesintek (ustekinumab-kfce)**

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

1. Has the patient been on this medication continuously for the last **6 months** excluding samples? ***Please select answer below:***
   ❑**NO** – this is **INITIATION** of therapy, please answer the questions on **PAGE 2**
   ❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the questions below:
2. Is this request for brand or generic? ❑Brand ❑Generic
3. Has the patient's condition improved or stabilized with therapy? ❑Yes ❑No
4. Does the patient have any active infections including active Tuberculosis (TB) or Hepatitis B Virus infection (HBV)? ❑Yes ❑No
5. Will the patient be given live vaccines while on this therapy? ❑Yes ❑No
6. Will Stelara be used in combination with another biologic *DMARD or targeted synthetic DMARD? ❑Yes* ❑No
   If YES, please specify: _____
   DMARDs: Actemra or an Actemra biosimilar, Avsola, Bimzelx, Cimzia, Cosentyx, Enbrel, Entyvio, Humira or a Humira biosimilar, Ilumya, Inflectra, Kevzara, Kineret, Olumiant, Orencia, Otezla, Remicade, Renflexis, Riabni, Rinvoq, Rituxan, Ruxience, Siliq, Simponi/Simponi Aria, Skyrizi, Sotyktu, Spevigo, Stelara or a Stelara biosimilar, Taltz, Tremfya, Truxima, Xeljanz/Xeljanz XR.
7. What is the patient's diagnosis?
   ❑Crohn's disease (CD)
   a. Does the prescriber agree not to exceed the FDA labeled maintenance dose of 90 mg subcutaneously every 8 weeks? ❑Yes ❑No
   b. Is this medication being requested as a change from Cimzia, Entyvio, Humira or a non-preferred biosimilar, Omvoh, or Stelara or a non-preferred biosimilar? ❑Yes* ❑No
      If YES, please select medication: ❑Cimzia ❑Entyvio ❑Humira or a non-preferred biosimilar ❑Omvoh ❑Stelara or a non-preferred biosimilar

   ❑Ulcerative colitis (UC)
   a. Does the prescriber agree not to exceed the FDA labeled maintenance dose of 90 mg subcutaneously every 8 weeks? ❑Yes ❑No
   b. Is this medication being requested as a change from Entyvio, Humira or a non-preferred biosimilar, Omvoh, Simponi, Stelara or a non-preferred biosimilar, Velsipity, or Zeposia? ❑Yes* ❑No
      If YES, please select medication: ❑Entyvio ❑Humira or a non-preferred biosimilar ❑Omvoh ❑Simponi ❑Stelara or a non-preferred biosimilar ❑Velsipity ❑Zeposia

PLEASE PROCEED TO PAGE 6 FOR ADDITIONAL DIAGNOSES

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PAGE 3 - PHYSICIAN COMPLETES

Patient Name: _____ **DOB:** _____ **Patient ID: R** _____

❑Plaque psoriasis (PsO)

a. **Age 6-17**: What is the patient's weight in either pounds (lbs) or kilograms (kg)? ***Please select answer below:***

❑**Less than 60kg (132lbs)**: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 0.75 milligrams per kilogram (mg/kg) subcutaneously every 12 weeks? ❑Yes ❑No

❑**60kg (132lbs) to 100kg (220lbs)**: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 45mg subcutaneously every 12 weeks? ❑Yes ❑No

❑**Greater than 100kg (220lbs):** Does the prescriber agree not to exceed the FDA labeled maintenance dose of 90mg subcutaneously every 12 weeks? ❑Yes ❑No

b. **Age 18 or Older**: What is the patient's weight in either pounds (lbs) or kilograms (kg)? ***Please select answer below:***

❑**Less than or equal to 100kg (220lbs)**: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 45mg subcutaneously every 12 weeks? ❑Yes ❑No

❑**Greater than 100kg (220lbs):** Does the prescriber agree not to exceed the FDA labeled maintenance dose of 90mg subcutaneously every 12 weeks? ❑Yes ❑No

c. Is this medication being requested as a change from Bimzelx, Cimzia, Cosentyx, Humira or a non-preferred biosimilar, Ilumya, Siliq, Sotyktu, or Stelara or a non-preferred biosimilar? ❑Yes***** ❑No

****If YES***, please select medication: ❑Bimzelx ❑Cimzia ❑Cosentyx ❑Humira or a non-preferred biosimilar ❑Ilumya ❑Siliq ❑Sotyktu ❑Stelara or a non-preferred biosimilar

❑Psoriatic arthritis (PsA)

a. **Age 6-17**: What is the patient's weight in either pounds (lbs) or kilograms (kg)? ***Please select answer below:***

❑**Less than 60kg (132lbs)**: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 0.75 milligrams per kilogram (mg/kg) subcutaneously every 12 weeks? ❑Yes ❑No

❑**60kg (132lbs) to 100kg (220lbs)**: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 45mg subcutaneously every 12 weeks? ❑Yes ❑No

❑**Greater than 100kg (220lbs):** Does the patient have a concurrent diagnosis of moderate to severe plaque psoriasis?

❑**Yes**: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 90 mg subcutaneously every 12 weeks? ❑Yes ❑No

❑**No:** Does the prescriber agree not to exceed the FDA labeled maintenance dose of 45mg subcutaneously every 12 weeks? ❑Yes ❑No

b. **Age 18 or Older**: What is the patient's weight in either pounds (lbs) or kilograms (kg)? ***Please select answer below:***

❑**Less than or equal to 100kg (220lbs)**: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 45mg subcutaneously every 12 weeks? ❑Yes ❑No

❑**Greater than 100kg (220lbs)**: Does the patient have a concurrent diagnosis of moderate to severe plaque psoriasis?

❑**Yes**: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 90 mg subcutaneously every 12 weeks? ❑Yes ❑No

❑**No:** Does the prescriber agree not to exceed the FDA labeled maintenance dose of 45mg subcutaneously every 12 weeks? ❑Yes ❑No

c. **Age 18 or older:** Is this medication being requested as a change from Bimzelx, Cimzia, Cosentyx, Humira or a non-preferred biosimilar, Orencia, Simponi, or Stelara or a non-preferred biosimilar? ❑Yes***** ❑No

****If YES***, please select medication: ❑Bimzelx ❑Cimzia ❑Cosentyx ❑Humira or a non-preferred biosimilar ❑Orencia ❑Simponi ❑Stelara or a non-preferred biosimilar

❑Other ***(please specify):*** _____

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Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		

PHYSICIAN COMPLETES

All approved requests for STELARA OR NON-PREFERRED BIOSIMILARS are subject to review by a clinical specialist for final validation and coverage determination once all required documentation has been received. Current utilization, including samples, does not guarantee approval of coverage. SUBMITTING THE PATIENT'S MEDICAL RECORDS IS REQUIRED.

INITIATION OF THERAPY

NOTE: Form must be completed in its **entirety** for processing

Please select medication:

❑**Stelara (ustekinumab)**	❑**Otulfi (BRAND)**	❑**Steqeyma (ustekinumab-stba)**
❑**Imuldosa (ustekinumab-srlf)**	❑**Selarsdi (ustekinumab-aekn)**	❑**Wezlana (ustekinumab-auub)**

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

DOCUMENTATION IS REQUIRED: Please ensure that all relevant medical records are submitted along with the correct page number(s).

1. Has the patient been on this medication continuously for the last **6 months** excluding samples? ***Please select answer below:***
   ❑ **YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the questions on **PAGE 14**
   ❑ **NO –** this is **INITIATION** of therapy, please answer the questions below:
2. Is this request for brand or generic? ❑ Brand ❑ Generic
3. Has the patient been tested for latent tuberculosis (TB)? ❑Yes***** ❑No
   ****If YES***, was the result of the test positive or negative for TB infection? ❑ Positive***** ❑ Negative
   ****If POSITIVE***, has the patient completed treatment or is the patient currently receiving treatment for latent TB? ❑Yes ❑No
4. Does the patient have any active infections including active TB or Hepatitis B Virus infection (HBV)? ❑Yes ❑No
5. Will the patient be given live vaccines while on this therapy? ❑Yes ❑No
6. Will Stelara be used in combination with another biologic *****DMARD or targeted synthetic DMARD? ❑Yes***** ❑No
   ****If YES***, please specify the medication: _____
   ****DMARDs: Actemra or an Actemra biosimilar, Avsola, Bimzelx, Cimzia, Cosentyx, Enbrel, Entyvio, Humira or a Humira biosimilar, Ilumya, Inflectra, Kevzara, Kineret, Olumiant, Orencia, Otezla, Remicade, Renflexis, Riabni, Rinvoq, Rituxan, Ruxience, Siliq, Simponi/Simponi Aria, Skyrizi, Sotyktu, Spevigo, Stelara or a Stelara biosimilar, Taltz, Tremfya, Truxima, Xeljanz/Xeljanz XR.***
7. What is the patient's diagnosis? **DOCUMENTATION IS REQUIRED: Please ensure that all relevant medical records are submitted along with the correct page number(s).**

   ❑Crohn's disease (CD), **please specify the medical record page number(s). PAGE(s)_____ of _____**
   a. Does the patient have moderate to severely active Crohn's disease (CD)? ❑Yes* ❑No
      ****If YES*, please specify the medical record page number(s). PAGE(s)_____ of _____**
   b. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to at least one conventional therapy option? ❑Yes* ❑No
      ****If YES*, please specify the medical record page number(s). PAGE(s)_____ of _____**
   c. Will the patient's first dose be given an IV infusion? ❑Yes ❑No

PLEASE PROCEED TO PAGE 8 FOR ADDITIONAL CROHN'S DISEASE RELATED QUESTIONS & OTHER DIAGNOSES

BlueCross BlueShield Federal Employee Program

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PAGE 3 - PHYSICIAN COMPLETES

Patient Name: _____ DOB: _____ Patient ID: R _____

Crohn's disease CONTINUED:

d. What is the patient's weight in either pounds (lbs) or kilograms (kg)? ***Please select answer below:***

❑**55kg (121lbs) or less**: Does the prescriber agree to administer 260mg for the initial IV infusion? ❑Yes ❑No

❑**Greater than 55kg (121lbs) to 85kg (187lbs)**: Does the prescriber agree to administer 390mg for the initial IV infusion? ❑Yes ❑No

❑**Greater than 85kg (187lbs)**: Does the prescriber agree to administer 520mg for the initial infusion? ❑Yes ❑No

e. Following the initial IV infusion, does the prescriber agree not to exceed the FDA labeled maintenance dose of 90 mg subcutaneously every 8 weeks? ❑Yes ❑No

f. **Standard/Basic Option Patient:** Has the patient tried and failed Rinvoq, Skyrizi, Tremfya, generic Hulio (adalimumab-fkjp-Humira biosimilar), Hyrimoz (Humira biosimilar), Pyzchiva (Stelara biosimilar), generic Otulfi (ustekinumab-aauz – Stelara biosimilar), or Yesintek (Stelara biosimilar)? ***Please select answer below:***

❑ **YES –Please specify the medication(s) and medical record page number(s).**

Medication(s): _____ PAGE(s)_____ of _____

❑ **NO – The patient has not tried and failed any of these medications.**

g. **Standard/Basic Option Patient:** Would you like to switch to a preferred medication? The preferred medications are Rinvoq, Skyrizi, Tremfya, generic Hulio (adalimumab-fkjp - Humira biosimilar), Hyrimoz (Humira biosimilar), Pyzchiva (Stelara biosimilar), generic Otulfi (ustekinumab-aauz - Stelara biosimilar), and Yesintek (Stelara biosimilar).
Please select answer below:

❑ **YES –** Please answer the questions below:

i. Please select the requested preferred medication: ❑Rinvoq ❑Skyrizi ❑Tremfya ❑Hyrimoz ❑generic Hulio (adalimumab-fkjp) ❑Pyzchiva ❑generic Otulfi (ustekinumab-aauz) ❑Yesintek

ii. Does the prescriber agree to review the plan criteria associated with the requested preferred medication to ensure that the medication is safe and appropriate for the patient? ❑Yes ❑No

❑ **NO –** Do not switch.

❑ **NO –** Do not switch however the patient has a medical exception. **Please specify the medical record page number(s).**
PAGE(s)_____ of _____

❑ **NO –** Do not switch however I would like to speak with a medical director to discuss the case. **Please specify the preferred date and time to contact, including the time zone, and the phone number: _____**

_____

h. **Blue Focus Patient:** This is a non-formulary medication. Please provide all formulary alternative medication(s) that have been tried and failed and specify the medical record page number(s) below:

❑**PAGE(s)_____ of _____ Formulary alternative medication(s):_____**

_____

❑ **The patient has not tried and failed any formulary alternatives.**

i. **Blue Focus Patient:** Would you like to switch to a preferred medication? The preferred medications are generic Hulio (adalimumab-fkjp - Humira biosimilar), Hyrimoz (Humira biosimilar), Pyzchiva (Stelara biosimilar), generic Otulfi (ustekinumab-aauz - Stelara biosimilar), and Yesintek (Stelara biosimilar). ***Please select answer below:***

❑ **YES –** Please answer the questions below:

i. Please select the requested preferred medication: ❑generic Hulio (adalimumab-fkjp) ❑Hyrimoz ❑Pyzchiva ❑generic Otulfi (ustekinumab-aauz) ❑Yesintek

ii. Does the prescriber agree to review the plan criteria associated with the requested preferred medication to ensure that the medication is safe and appropriate for the patient? ❑Yes ❑No

❑ **NO –** Do not switch.

PLEASE PROCEED TO PAGE 9 FOR ADDITIONAL DIAGNOSES

BlueCross BlueShield Federal Employee Program

STELARA
PRIOR APPROVAL REQUEST

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

PAGE 2 - PHYSICIAN COMPLETES

Patient Name: _____ DOB: _____ Patient ID: R _____

❑Plaque psoriasis (PsO), **please specify the medical record page number(s). PAGE(s)_____ of _____**

a. Does the patient have moderate to severe plaque psoriasis (PsO)? ❑Yes* ❑No
***If YES*, please specify the medical record page number(s). PAGE(s)_____ of _____**

b. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to conventional systemic therapy? ***Please select answer below:***

❑Inadequate treatment response* ❑Intolerance or contraindication* ❑Has not tried conventional systemic therapy

***Please specify the medical record page number(s). PAGE(s)_____ of _____**

c. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to phototherapy?
Please select answer: ❑Inadequate treatment response* ❑Intolerance or contraindication* ❑Has not tried phototherapy

***Please specify the medical record page number(s). PAGE(s)_____ of _____**

d. **Age 6-17**: What is the patient's weight in either pounds (lbs) or kilograms (kg)? ***Please select answer below:***

❑**Less than 60kg (132lbs)**: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 0.75 milligrams per kilogram (mg/kg) subcutaneously every 12 weeks? ❑Yes ❑No

❑**60kg (132lbs) to 100kg (220lbs)**: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 45mg subcutaneously every 12 weeks? ❑Yes ❑No

❑**Greater than 100kg (220lbs):** Does the prescriber agree not to exceed the FDA labeled maintenance dose of 90mg subcutaneously every 12 weeks? ❑Yes ❑No

e. **Age 18 or Older**: What is the patient's weight in either pounds (lbs) or kilograms (kg)? ***Please select answer below:***

❑**Less than or equal to 100kg (220lbs)**: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 45mg subcutaneously every 12 weeks? ❑Yes ❑No

❑**Greater than 100kg (221lbs):** Does the prescriber agree not to exceed the FDA labeled maintenance dose of 90mg subcutaneously every 12 weeks? ❑Yes ❑No

f. **Blue Focus Patient:** This is a non-formulary medication. Please provide all formulary alternative medication(s) that have been tried and failed and specify the medical record page number(s) below:

❑**PAGE(s)_____ of _____ Formulary alternative medication(s):_____**

_____

❑**The patient has not tried and failed any formulary alternatives.**

g. **Blue Focus Patient:** Would you like to switch to a preferred medication? The preferred medications are Enbrel, generic Hulio (adalimumab-fkjp - Humira biosimilar), Hyrimoz (Humira biosimilar), Otezla, Pyzchiva (Stelara biosimilar), generic Otulfi (ustekinumab-aauz - Stelara Biosimilar), and Yesintek (Stelara biosimilar). ***Please select answer below:***

❑**YES –** Please answer the questions specific to the patient's age below:

i. **Age 12 or older:** Please select the requested preferred medication: ❑Enbrel 25 mg ❑Enbrel 50 mg ❑Otezla ❑generic Hulio (adalimumab-fkjp) ❑Hyrimoz ❑Pyzchiva ❑generic Otulfi (ustekinumab-aauz) ❑Yesintek

ii. **Age 6 to 11:** Please select the requested preferred medication: ❑Enbrel 25 mg ❑Enbrel 50 mg ❑Otezla ❑Pyzchiva ❑generic Otulfi (ustekinumab-aauz) ❑Yesintek

iii. **Age 6 or older:** Does the prescriber agree to review the plan criteria associated with the requested preferred medication to ensure that the medication is safe and appropriate for the patient? ❑Yes ❑No

❑**NO –** Do not switch.

h. **Standard/Basic Option Patient:** Has the patient tried and failed Enbrel, generic Hulio (adalimumab-fkjp – Humira biosimilar), Hyrimoz (Humira biosimilar), Otezla, Skyrizi, Pyzchiva (Stelara biosimilar), generic Otulfi (ustekinumab-aauz - Stelara biosimilar), Yesintek (Stelara biosimilar), Taltz, or Tremfya? ***Please select answer below:***

❑**YES –Please specify the medication(s) and medical record page number(s).**

Medication(s): _____ PAGE(s)_____ of _____

❑**NO – The patient has not tried and failed any of these medications.**

PLEASE PROCEED TO PAGE 10 FOR ADDITIONAL PLAQUE PSORIASIS RELATED QUESTIONS & OTHER DIAGNOSES

PAGE 2 - PHYSICIAN COMPLETES

Patient Name: _____ DOB: _____ Patient ID: R _____

Plaque psoriasis CONTINUED:

i. **Standard/Basic Option Patient:** Would you like to switch to a preferred medication? The preferred medications are Enbrel, generic Hulio (adalimumab-fkjp - Humira biosimilar), Hyrimoz (Humira biosimilar), Otezla, Skyrizi, Pyzchiva (Stelara biosimilar), generic Otulfi (ustekinumab-aauz - Stelara Biosimilar), Yesintek (Stelara biosimilar), Taltz, and Tremfya. ***Please select answer below:***

❑ **YES –** Please answer the questions specific to the patient's age below:

i. **Age 18 or older:** Please select the requested preferred medication: ❑Enbrel 25 mg ❑Enbrel 50 mg ❑generic Hulio (adalimumab-fkjp) ❑Hyrimoz ❑Otezla ❑Skyrizi ❑Taltz ❑Tremfya ❑Pyzchiva ❑generic Otulfi (ustekinumab-aauz) ❑Yesintek

ii. **Age 12 to 17:** Please select the requested preferred medication: ❑Enbrel 25 mg ❑Enbrel 50 mg ❑generic Hulio (adalimumab-fkjp) ❑Hyrimoz ❑Otezla ❑Taltz ❑Tremfya ❑Pyzchiva ❑generic Otulfi (ustekinumab-aauz) ❑Yesintek

iii. **Age 6 to 11:** Please select the requested preferred medication: ❑Enbrel 25 mg ❑Enbrel 50 mg ❑Otezla ❑Taltz ❑Tremfya ❑Pyzchiva ❑generic Otulfi (ustekinumab-aauz) ❑Yesintek

iv. **Age 6 or older:** Does the prescriber agree to review the plan criteria associated with the requested preferred medication to ensure that the medication is safe and appropriate for the patient? ❑Yes ❑No

❑ **NO –** Do not switch.

❑ **NO –** Do not switch however the patient has a medical exception. **Please specify the medical record page number(s). PAGE(s)_____ of _____**

❑ **NO –** Do not switch however I would like to speak with a medical director to discuss the case. **Please specify the preferred date and time to contact, including the time zone, and the phone number: _____**

_____

❑Psoriatic arthritis (PsA), **please specify the medical record page number(s). PAGE(s)_____ of _____**

a. Does the patient have active psoriatic arthritis (PsA)? ❑Yes* ❑No
***If YES*, please specify the medical record page number(s). PAGE(s)_____ of _____**

b. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to a 3-month trial of at least one conventional DMARD? ❑Yes* ❑No
***If YES*, please specify the medical record page number(s). PAGE(s)_____ of _____**

c. **Age 6-17**: What is the patient's weight in either pounds (lbs) or kilograms (kg)? ***Please select answer below:***

❑**Less than 60kg (132lbs)**: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 0.75 milligrams per kilogram (mg/kg) subcutaneously every 12 weeks? ❑Yes ❑No

❑**60kg (132lbs) to 100kg (220lbs)**: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 45mg subcutaneously every 12 weeks? ❑Yes ❑No

❑**Greater than 100kg (220lbs):** Does the patient have a concurrent diagnosis of moderate to severe plaque psoriasis?

❑**Yes**: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 90 mg subcutaneously every 12 weeks? ❑Yes ❑No

❑**No:** Does the prescriber agree not to exceed the FDA labeled maintenance dose of 45mg subcutaneously every 12 weeks? ❑Yes ❑No

d. **Age 18 or Older**: What is the patient's weight in either pounds (lbs) or kilograms (kg)? ***Please select answer below:***

❑**Less than or equal to 100kg (220lbs)**: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 45mg subcutaneously every 12 weeks? ❑Yes ❑No

❑**Greater than 100kg (220lbs)**: Does the patient have a concurrent diagnosis of moderate to severe plaque psoriasis?

❑**Yes**: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 90 mg subcutaneously every 12 weeks? ❑Yes ❑No

❑**No:** Does the prescriber agree not to exceed the FDA labeled maintenance dose of 45mg subcutaneously every 12 weeks? ❑Yes ❑No

PLEASE PROCEED TO PAGE 11 FOR ADDITIONAL PSORIATIC ARTHRITIS RELATED QUESTIONS & OTHER DIAGNOSES

BlueCross BlueShield Federal Employee Program

STELARA
PRIOR APPROVAL REQUEST

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

PAGE 2 - PHYSICIAN COMPLETES

Patient Name: _____ DOB: _____ Patient ID: R _____

Psoriatic arthritis CONTINUED:

d. **Age 18 or older - Standard/Basic Option Patient:** Has the patient tried and failed Enbrel, generic Hulio (adalimumab-fkjp – Humira biosimilar), Hyrimoz (Humira biosimilar), Otezla, Rinvoq/LQ, Skyrizi, Pyzchiva (Stelara biosimilar), generic Otulfi (ustekinumab-aauz - Stelara biosimilar), Yesintek (Stelara biosimilar), Taltz, Tremfya, or Xeljanz/Xeljanz XR? ***Please select answer below:***

❑ **YES –Please specify the medication(s) and medical record page number(s).**

Medication(s): _____ PAGE(s)_____ of _____

❑ **NO – The patient has not tried and failed any of these medications.**

e. **Age 18 or older - Standard/Basic Option Patient:** Would you like to switch to a preferred medication? The preferred medications are Enbrel, generic Hulio (adalimumab-fkjp - Humira biosimilar), Hyrimoz (Humira biosimilar), Otezla, Rinvoq/LQ, Skyrizi, Pyzchiva (Stelara biosimilar), generic Otulfi (ustekinumab-aauz - Stelara Biosimilar), Yesintek (Stelara biosimilar), Taltz, Tremfya, and Xeljanz/Xeljanz XR. ***Please select answer below:***

❑ **YES –** Please answer the questions below:

i. Please select the requested preferred medication: ❑Enbrel 25 mg ❑Enbrel 50 mg ❑Otezla ❑Rinvoq/LQ ❑generic Hulio (adalimumab-fkjp) ❑Hyrimoz ❑Skyrizi ❑Taltz ❑Tremfya ❑Pyzchiva ❑generic Otulfi (ustekinumab-aauz) ❑Yesintek ❑Xeljanz 5 mg ❑Xeljanz XR 11 mg

ii. Does the prescriber agree to review the plan criteria associated with the requested preferred medication to ensure that the medication is safe and appropriate for the patient? ❑Yes ❑No

❑ **NO –** Do not switch.

❑ **NO –** Do not switch however the patient has a medical exception. **Please specify the medical record page number(s). PAGE(s)_____ of _____**

❑ **NO –** Do not switch however I would like to speak with a medical director to discuss the case. **Please specify the preferred date and time to contact, including the time zone, and the phone number: _____**

_____

f. **Age 6 to 17 - Standard/Basic Option Patient:** Please answer the following questions:

i. Would you like to switch to a preferred medication? The preferred medications are Pyzchiva (Stelara biosimilar), generic Otulfi (ustekinumab-aauz - Stelara biosimilar), and Yesintek (Stelara biosimilar). ***Please select answer below:***

❑ **YES, switch to Pyzchiva.**
❑ **YES, switch to generic Otulfi.**
❑ **YES, switch to Yesintek.**

❑ **NO –** Please answer the questions below:

1) Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to the preferred medications Pyzchiva (Stelara biosimilar), generic Otulfi (ustekinumab-aauz - Stelara biosimilar), or Yesintek (Stelara biosimilar)? ❑Yes* ❑No

***If YES*, please specify the medical record page number(s). PAGE(s)_____ of _____**

2) Is there a clinical reason for not trying the preferred medications Pyzchiva (Stelara biosimilar), generic Otulfi (ustekinumab-aauz - Stelara biosimilar), or Yesintek (Stelara biosimilar)? ❑Yes* ❑No

***If YES*, please specify the medical record page number(s). PAGE(s)_____ of _____**

g. **Blue Focus Patient:** This is a non-formulary medication. Please provide all formulary alternative medication(s) that have been tried and failed and specify the medical record page number(s) below:

❑**PAGE(s)_____ of _____ Formulary alternative medication(s):_____**

_____

❑ **The patient has not tried and failed any formulary alternatives.**

PLEASE PROCEED TO PAGE 12 FOR ADDITIONAL PSORIATIC ARTHRITIS RELATED QUESTIONS & OTHER DIAGNOSES

PAGE 3 - PHYSICIAN COMPLETES

Patient Name: _____ DOB: _____ Patient ID: R _____

Psoriatic arthritis CONTINUED:

h. **Blue Focus Patient:** Would you like to switch to a preferred medication? The preferred medications are Enbrel, generic Hulio (adalimumab-fkjp - Humira biosimilar), Hyrimoz (Humira biosimilar), Otezla, Pyzchiva (Stelara biosimilar), generic Otulfi (ustekinumab-aauz - Stelara biosimilar), and Yesintek (Stelara biosimilar).
Please select answer below:

❑ **YES –** Please answer the questions specific to the patient's age below:

i. **Age 18 or older:** Please select the requested preferred medication: ❑Enbrel 25 mg ❑Enbrel 50 mg ❑Otezla ❑generic Hulio (adalimumab-fkjp) ❑Hyrimoz ❑Pyzchiva ❑generic Otulfi (ustekinumab-aauz) ❑Yesintek

ii. **Age 6 to 17:** Please select the requested preferred medication: ❑Pyzchiva ❑generic Otulfi (ustekinumab-aauz) ❑Yesintek

iii. **Age 6 or older:** Does the prescriber agree to review the plan criteria associated with the requested preferred medication to ensure that the medication is safe and appropriate for the patient? ❑Yes ❑No

❑ **NO –** Do not switch.

❑Ulcerative colitis (UC), **please specify the medical record page number(s). PAGE(s)_____ of _____**

a. Does the patient have a diagnosis of moderate to severely active ulcerative colitis (UC)? ❑Yes* ❑No
***If YES*, please specify the medical record page number(s). PAGE(s)_____ of _____**

b. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to at least one conventional therapy option? ❑Yes* ❑No
***If YES*, please specify the medical record page number(s). PAGE(s)_____ of _____**

c. Will the patient's first dose be given as an IV infusion? ❑Yes ❑No

d. What is the patient's weight in either pounds (lbs) or kilograms (kg)? ***Please select answer below:***

❑**55kg (121lbs) or less**: Does the prescriber agree to administer 260mg for the initial IV infusion? ❑Yes ❑No

❑**Greater than 55kg (121lbs) to 85kg (187lbs)**: Does the prescriber agree to administer 390mg for the initial IV infusion? ❑Yes ❑No

❑**Greater than 85kg (187lbs)**: Does the prescriber agree to administer 520mg for the initial infusion? ❑Yes ❑No

e. Following the initial IV infusion, does the prescriber agree not to exceed the FDA labeled maintenance dose of 90 mg subcutaneously every 8 weeks? ❑Yes ❑No

f. **Blue Focus Patient:** This is a non-formulary medication. Please provide all formulary alternative medication(s) that have been tried and failed and specify the medical record page number(s) below:
❑**PAGE(s)_____ of _____ Formulary alternative medication(s):_____**

_____

❑ **The patient has not tried and failed any formulary alternatives.**

g. **Blue Focus Patient:** Would you like to switch to a preferred medication? The preferred medications are generic Hulio (adalimumab-fkjp - Humira biosimilar), Hyrimoz (Humira biosimilar), Pyzchiva (Stelara biosimilar), generic Otulfi (ustekinumab-aauz - Stelara Biosimilar), and Yesintek (Stelara biosimilar). ***Please select answer below:***

❑ **YES –** Please answer the questions below:

i. Please select the requested preferred medication: ❑generic Hulio (adalimumab-fkjp) ❑Hyrimoz ❑Pyzchiva ❑generic Otulfi (ustekinumab-aauz) ❑Yesintek

ii. Does the prescriber agree to review the plan criteria associated with the requested preferred medication to ensure that the medication is safe and appropriate for the patient? ❑Yes ❑No

❑ **NO –** Do not switch.

PLEASE PROCEED TO PAGE 13 FOR ADDITIONAL ULCERATIVE COLITIS RELATED QUESTIONS & OTHER DIAGNOSES

BlueCross BlueShield Federal Employee Program

STELARA
PRIOR APPROVAL REQUEST

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

PAGE 3 - PHYSICIAN COMPLETES

Patient Name: _____ DOB: _____ Patient ID: R _____

Ulcerative colitis CONTINUED:

h. **Standard/Basic Option Patient:** Has the patient tried and failed generic Hulio (adalimumab-fkjp - Humira biosimilar), Hyrimoz (Humira biosimilar), Rinvoq, Skyrizi, Pyzchiva (Stelara biosimilar), generic Otulfi (ustekinumab-aauz - Stelara biosimilar), Yesintek (Stelara biosimilar), Tremfya, or Xeljanz/Xeljanz XR? ***Please select answer below:***

❑ **YES –Please specify the medication(s) and medical record page number(s).**

Medication(s): _____ PAGE(s)_____ of _____

❑ **NO – The patient has not tried and failed any of these medications.**

i. **Standard/Basic Option Patient:** Would you like to switch to a preferred medication? The preferred medications are generic Hulio (adalimumab-fkjp - Humira biosimilar), Hyrimoz (Humira biosimilar), Rinvoq, Skyrizi, Pyzchiva (Stelara biosimilar), generic Otulfi (ustekinumab-aauz - Stelara biosimilar), Yesintek (Stelara biosimilar), Tremfya, and Xeljanz/Xeljanz XR. ***Please select answer below:***

❑ **YES –** Please answer the questions below:

i. Please select the requested preferred medication: ❑Rinvoq ❑Skyrizi ❑Tremfya ❑Hyrimoz ❑generic Hulio (adalimumab-fkjp) ❑Pyzchiva ❑generic Otulfi (ustekinumab-aauz) ❑Yesintek ❑ Xeljanz 5mg ❑Xeljanz 10mg ❑ Xeljanz XR 11mg ❑Xeljanz XR 22mg

ii. Does the prescriber agree to review the plan criteria associated with the requested preferred medication to ensure that the medication is safe and appropriate for the patient? ❑Yes ❑No

❑ **NO –** Do not switch.

❑ **NO –** Do not switch however the patient has a medical exception. **Please specify the medical record page number(s). PAGE(s)_____ of _____**

❑ **NO –** Do not switch however I would like to speak with a medical director to discuss the case. **Please specify the preferred date and time to contact, including the time zone, and the phone number: _____**

_____

❑Other ***(please specify):*** _____

BlueCross BlueShield Federal Employee Program

STELARA
PRIOR APPROVAL REQUEST

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		

PHYSICIAN COMPLETES

All approved requests for STELARA OR NON-PREFERRED BIOSIMILARS are subject to review by a clinical specialist for final validation and coverage determination once all required documentation has been received. Current utilization, including samples, does not guarantee approval of coverage. SUBMITTING THE PATIENT'S MEDICAL RECORDS IS REQUIRED.

CONTINUATION OF THERAPY (PA RENEWAL)

NOTE: Form must be completed in its **entirety** for processing

Please select medication:

❑**Stelara (ustekinumab)**	❑**Otulfi (BRAND)**	❑**Steqeyma (ustekinumab-stba)**
❑**Imuldosa (ustekinumab-srlf)**	❑**Selarsdi (ustekinumab-aekn)**	❑**Wezlana (ustekinumab-auub)**

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

DOCUMENTATION IS REQUIRED: Please ensure that all relevant medical records are submitted along with the correct page number(s).

1. Has the patient been on this medication continuously for the last **6 months** excluding samples? ***Please select answer below:***
   ❑**NO** – this is **INITIATION** of therapy, please answer the questions on **PAGE 7**
   ❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the questions below:
2. Is this request for brand or generic? ❑Brand ❑Generic
3. Has the patient's condition improved or stabilized with therapy? ❑Yes* ❑No
   ***If YES*, please specify the medical record page number(s). PAGE(s)_____ of _____**
4. Does the patient have any active infections including active tuberculosis (TB) or hepatitis B virus infection (HBV)? ❑Yes ❑No
5. Will the patient be given live vaccines while on this therapy? ❑Yes ❑No
6. Will Stelara be used in combination with another biologic *DMARD or targeted synthetic DMARD? ❑Yes* ❑No
   If YES, please specify: _____
   DMARDs: Actemra or an Actemra biosimilar, Avsola, Bimzelx, Cimzia, Cosentyx, Enbrel, Entyvio, Humira or a Humira biosimilar, Ilumya, Inflectra, Kevzara, Kineret, Olumiant, Orencia, Otezla, Remicade, Renflexis, Riabni, Rinvoq, Rituxan, Ruxience, Siliq, Simponi/Simponi Aria, Skyrizi, Sotyktu, Spevigo, Stelara or a Stelara biosimilar, Taltz, Tremfya, Truxima, Xeljanz/Xeljanz XR.
7. What is the patient's diagnosis?
   ❑Crohn's disease (CD), **please specify the medical record page number(s). PAGE(s)_____ of _____**
   a. Does the prescriber agree not to exceed the FDA labeled maintenance dose of 90 mg subcutaneously every 8 weeks? ❑Yes ❑No
   b. **Blue Focus Patient:** This is a non-formulary medication. Please provide all formulary alternative medication(s) that have been tried and failed and specify the medical record page number(s) below:
   ❑**PAGE(s)_____ of _____ Formulary alternative medication(s):_____**
   _____
   ❑**The patient has not tried and failed any formulary alternatives.**

PLEASE PROCEED TO PAGE 15 FOR ADDITIONAL CROHN'S DISEASE RELATED QUESTIONS & OTHER DIAGNOSES

PAGE 3 - PHYSICIAN COMPLETES

Patient Name: _____ DOB: _____ Patient ID: R _____

Crohn's disease CONTINUED:

c. **Blue Focus Patient:** Would you like to switch to a preferred medication? The preferred medications are generic Hulio (adalimumab-fkjp - Humira biosimilar), Hyrimoz (Humira biosimilar), Pyzchiva (Stelara biosimilar), generic Otulfi (ustekinumab-aauz - Stelara biosimilar), and Yesintek (Stelara biosimilar). ***Please select answer below:***

❑ **YES –** Please answer the questions below:

i. Please select the requested preferred medication: ❑generic Hulio (adalimumab-fkjp) ❑Hyrimoz ❑Pyzchiva ❑generic Otulfi (ustekinumab-aauz) ❑Yesintek

ii. Does the prescriber agree to review the plan criteria associated with the requested preferred medication to ensure that the medication is safe and appropriate for the patient? ❑Yes ❑No

❑ **NO –** Do not switch.

d. **Standard/Basic Option Patient:** Has the patient tried and failed Rinvoq, Skyrizi, Tremfya, generic Hulio (adalimumab-fkjp-Humira biosimilar), Hyrimoz (Humira biosimilar), Pyzchiva (Stelara biosimilar), generic Otulfi (ustekinumab-aauz – Stelara biosimilar), or Yesintek (Stelara biosimilar)? ***Please select answer below:***

❑ **YES –Please specify the medication(s) and medical record page number(s).**

Medication(s): _____ PAGE(s)_____ of _____

❑ **NO – The patient has not tried and failed any of these medications.**

e. **Standard/Basic Option Patient:** Would you like to switch to a preferred medication? The preferred medications are Rinvoq, Skyrizi, Tremfya, generic Hulio (adalimumab-fkjp - Humira biosimilar), Hyrimoz (Humira biosimilar), Pyzchiva (Stelara biosimilar), generic Otulfi (ustekinumab-aauz - Stelara biosimilar), and Yesintek (Stelara biosimilar).
Please select answer below:

❑ **YES –** Please answer the questions below:

i. Please select the requested preferred medication: ❑Rinvoq ❑Skyrizi ❑Tremfya ❑Hyrimoz ❑generic Hulio (adalimumab-fkjp) ❑Pyzchiva ❑generic Otulfi (ustekinumab-aauz) ❑Yesintek

ii. Does the prescriber agree to review the plan criteria associated with the requested preferred medication to ensure that the medication is safe and appropriate for the patient? ❑Yes ❑No

❑ **NO –** Do not switch.

❑ **NO –** Do not switch however the patient has a medical exception. **Please specify the medical record page number(s). PAGE(s)_____ of _____**

❑ **NO –** Do not switch however I would like to speak with a medical director to discuss the case. **Please specify the preferred date and time to contact, including the time zone, and the phone number: _____**

_____

❑Plaque psoriasis (PsO), **please specify the medical record page number(s). PAGE(s)_____ of _____**

a. **Age 6-17**: What is the patient's weight in either pounds (lbs) or kilograms (kg)? ***Please select answer below:***

❑**Less than 60kg (132lbs)**: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 0.75 milligrams per kilogram (mg/kg) subcutaneously every 12 weeks? ❑Yes ❑No

❑**60kg (132lbs) to 100kg (220lbs)**: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 45mg subcutaneously every 12 weeks? ❑Yes ❑No

❑**Greater than 100kg (220lbs):** Does the prescriber agree not to exceed the FDA labeled maintenance dose of 90mg subcutaneously every 12 weeks? ❑Yes ❑No

b. **Age 18 or Older**: What is the patient's weight in either pounds (lbs) or kilograms (kg)? ***Please select answer below:***

❑**Less than or equal to 100kg (220lbs)**: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 45mg subcutaneously every 12 weeks? ❑Yes ❑No

❑**Greater than 100kg (220lbs):** Does the prescriber agree not to exceed the FDA labeled maintenance dose of 90mg subcutaneously every 12 weeks? ❑Yes ❑No

PLEASE PROCEED TO PAGE 16 FOR ADDITIONAL PLAQUE PSORIASIS RELATED QUESTIONS & OTHER DIAGNOSES

PAGE 3 - PHYSICIAN COMPLETES

Patient Name: _____ DOB: _____ Patient ID: R _____

Plaque psoriasis CONTINUED:

c. **Standard/Basic Option Patient:** Has the patient tried and failed Enbrel, generic Hulio (adalimumab-fkjp – Humira biosimilar), Hyrimoz (Humira biosimilar), Otezla, Skyrizi, Pyzchiva (Stelara biosimilar), generic Otulfi (ustekinumab-aauz - Stelara biosimilar), Yesintek (Stelara biosimilar), Taltz, or Tremfya? ***Please select answer below:***

❑ **YES –Please specify the medication(s) and medical record page number(s).**

Medication(s): _____ PAGE(s)_____ of _____

❑ **NO – The patient has not tried and failed any of these medications.**

d. **Standard/Basic Option Patient:** Would you like to switch to a preferred medication? The preferred medications are Enbrel, generic Hulio (adalimumab-fkjp - Humira biosimilar), Hyrimoz (Humira biosimilar), Otezla, Skyrizi, Pyzchiva (Stelara biosimilar), generic Otulfi (ustekinumab-aauz - Stelara Biosimilar), Yesintek (Stelara biosimilar), Taltz, and Tremfya. ***Please select answer below:***

❑ **YES –** Please answer the questions specific to the patient's age below:

i. **Age 18 or older:** Please select the requested preferred medication: ❑Enbrel 25 mg ❑Enbrel 50 mg ❑generic Hulio (adalimumab-fkjp) ❑Hyrimoz ❑Otezla ❑Skyrizi ❑Taltz ❑Tremfya ❑Pyzchiva ❑generic Otulfi (ustekinumab-aauz) ❑Yesintek

ii. **Age 12 to 17:** Please select the requested preferred medication: ❑Enbrel 25 mg ❑Enbrel 50 mg ❑generic Hulio (adalimumab-fkjp) ❑Hyrimoz ❑Otezla ❑Taltz ❑Tremfya ❑Pyzchiva ❑generic Otulfi (ustekinumab-aauz) ❑Yesintek

iii. **Age 6 to 11:** Please select the requested preferred medication: ❑Enbrel 25 mg ❑Enbrel 50 mg ❑Otezla ❑Taltz ❑Tremfya ❑Pyzchiva ❑generic Otulfi (ustekinumab-aauz) ❑Yesintek

iv. **Age 6 or older:** Does the prescriber agree to review the plan criteria associated with the requested preferred medication to ensure that the medication is safe and appropriate for the patient? ❑Yes ❑No

❑ **NO –** Do not switch.

❑ **NO –** Do not switch however the patient has a medical exception. **Please specify the medical record page number(s). PAGE(s)_____ of _____**

❑ **NO –** Do not switch however I would like to speak with a medical director to discuss the case. **Please specify the preferred date and time to contact, including the time zone, and the phone number: _____**

_____

e. **Blue Focus Patient:** This is a non-formulary medication. Please provide all formulary alternative medication(s) that have been tried and failed and specify the medical record page number(s) below:

❑**PAGE(s)_____ of _____ Formulary alternative medication(s):_____**

_____

❑ **The patient has not tried and failed any formulary alternatives.**

f. **Blue Focus Patient:** Would you like to switch to a preferred medication? The preferred medications are Enbrel, generic Hulio (adalimumab-fkjp - Humira biosimilar), Hyrimoz (Humira biosimilar), Otezla, Pyzchiva (Stelara biosimilar), generic Otulfi (ustekinumab-aauz - Stelara Biosimilar), and Yesintek (Stelara biosimilar). ***Please select answer below:***

❑ **YES –** Please answer the questions specific to the patient's age below:

i. **Age 12 or older:** Please select the requested preferred medication: ❑Enbrel 25 mg ❑Enbrel 50 mg ❑Otezla ❑generic Hulio (adalimumab-fkjp) ❑Hyrimoz ❑Pyzchiva ❑generic Otulfi (ustekinumab-aauz) ❑Yesintek

ii. **Age 6 to 11:** Please select the requested preferred medication: ❑Enbrel 25 mg ❑Enbrel 50 mg ❑Otezla ❑Pyzchiva ❑generic Otulfi (ustekinumab-aauz) ❑Yesintek

iii. **Age 6 or older:** Does the prescriber agree to review the plan criteria associated with the requested preferred medication to ensure that the medication is safe and appropriate for the patient? ❑Yes ❑No

❑ **NO –** Do not switch.

PLEASE PROCEED TO PAGE 17 FOR ADDITIONAL DIAGNOSES

BlueCross BlueShield Federal Employee Program

STELARA
PRIOR APPROVAL REQUEST

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

PAGE 2 - PHYSICIAN COMPLETES

Patient Name: _____ DOB: _____ Patient ID: R _____

❑Psoriatic arthritis (PsA), **please specify the medical record page number(s). PAGE(s)_____ of _____**

a. **Age 6-17**: What is the patient's weight in either pounds (lbs) or kilograms (kg)? ***Please select answer below:***

❑**Less than 60kg (132lbs)**: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 0.75 milligrams per kilogram (mg/kg) subcutaneously every 12 weeks? ❑Yes ❑No

❑**60kg (132lbs) to 100kg (220lbs)**: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 45mg subcutaneously every 12 weeks? ❑Yes ❑No

❑**Greater than 100kg (220lbs):** Does the patient have a concurrent diagnosis of moderate to severe plaque psoriasis?

❑**Yes**: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 90 mg subcutaneously every 12 weeks? ❑Yes ❑No

❑**No:** Does the prescriber agree not to exceed the FDA labeled maintenance dose of 45mg subcutaneously every 12 weeks? ❑Yes ❑No

b. **Age 18 or Older**: What is the patient's weight in either pounds (lbs) or kilograms (kg)? ***Please select answer below:***

❑**Less than or equal to 100kg (220lbs)**: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 45mg subcutaneously every 12 weeks? ❑Yes ❑No

❑**Greater than 100kg (220lbs)**: Does the patient have a concurrent diagnosis of moderate to severe plaque psoriasis?

❑**Yes**: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 90 mg subcutaneously every 12 weeks? ❑Yes ❑No

❑**No:** Does the prescriber agree not to exceed the FDA labeled maintenance dose of 45mg subcutaneously every 12 weeks? ❑Yes ❑No

c. **Age 18 or older - Standard/Basic Option Patient:** Has the patient tried and failed Enbrel, generic Hulio (adalimumab-fkjp – Humira biosimilar), Hyrimoz (Humira biosimilar), Otezla, Rinvoq/LQ, Skyrizi, Pyzchiva (Stelara biosimilar), generic Otulfi (ustekinumab-aauz - Stelara biosimilar), Yesintek (Stelara biosimilar), Taltz, Tremfya, or Xeljanz/Xeljanz XR? ***Please select answer below:***

❑ **YES –Please specify the medication(s) and medical record page number(s).**

Medication(s): _____ PAGE(s)_____ of _____

❑ **NO – The patient has not tried and failed any of these medications.**

d. **Age 18 or older - Standard/Basic Option Patient:** Would you like to switch to a preferred medication? The preferred medications are Enbrel, generic Hulio (adalimumab-fkjp - Humira biosimilar), Hyrimoz (Humira biosimilar), Otezla, Rinvoq/LQ, Skyrizi, Pyzchiva (Stelara biosimilar), generic Otulfi (ustekinumab-aauz - Stelara Biosimilar), Yesintek (Stelara biosimilar), Taltz, Tremfya, and Xeljanz/Xeljanz XR. ***Please select answer below:***

❑ **YES –** Please answer the questions below:

i. Please select the requested preferred medication: ❑Enbrel 25 mg ❑Enbrel 50 mg ❑Otezla ❑Rinvoq/LQ ❑generic Hulio (adalimumab-fkjp) ❑Hyrimoz ❑Skyrizi ❑Taltz ❑Tremfya ❑Pyzchiva ❑generic Otulfi (ustekinumab-aauz) ❑Yesintek ❑Xeljanz 5 mg ❑Xeljanz XR 11 mg

ii. Does the prescriber agree to review the plan criteria associated with the requested preferred medication to ensure that the medication is safe and appropriate for the patient? ❑Yes ❑No

❑ **NO –** Do not switch.

❑ **NO –** Do not switch however the patient has a medical exception. **Please specify the medical record page number(s). PAGE(s)_____ of _____**

❑ **NO –** Do not switch however I would like to speak with a medical director to discuss the case. **Please specify the preferred date and time to contact, including the time zone, and the phone number: _____**

_____

PLEASE PROCEED TO PAGE 18 FOR ADDITIONAL PSORIATIC ARTHRITIS RELATED QUESTIONS & OTHER DIAGNOSES

PAGE 2 - PHYSICIAN COMPLETES

Patient Name: _____ DOB: _____ Patient ID: R _____

Psoriatic arthritis CONTINUED:

e. **Age 6 to 17 - Standard/Basic Option Patient:** Please answer the following questions:

i. Would you like to switch to a preferred medication? The preferred medications are Pyzchiva (Stelara biosimilar), generic Otulfi (ustekinumab-aauz - Stelara biosimilar), and Yesintek (Stelara biosimilar). ***Please select answer below:***

❑ **YES, switch to Pyzchiva.**
❑ **YES, switch to generic Otulfi.**
❑ **YES, switch to Yesintek.**

❑ **NO –** Please answer the questions below:

1) Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to the preferred medications Pyzchiva (Stelara biosimilar), generic Otulfi (ustekinumab-aauz - Stelara biosimilar), or Yesintek (Stelara biosimilar)? ❑Yes* ❑No

***If YES*, please specify the medical record page number(s). PAGE(s)_____ of _____**

2) Is there a clinical reason for not trying the preferred medications Pyzchiva (Stelara biosimilar), generic Otulfi (ustekinumab-aauz - Stelara biosimilar), or Yesintek (Stelara biosimilar)? ❑Yes* ❑No

***If YES*, please specify the medical record page number(s). PAGE(s)_____ of _____**

f. **Blue Focus Patient:** This is a non-formulary medication. Please provide all formulary alternative medication(s) that have been tried and failed and specify the medical record page number(s) below:

❑**PAGE(s)_____ of _____ Formulary alternative medication(s):_____**

_____

❑ **The patient has not tried and failed any formulary alternatives.**

g. **Blue Focus Patient:** Would you like to switch to a preferred medication? The preferred medications are Enbrel, generic Hulio (adalimumab-fkjp - Humira biosimilar), Hyrimoz (Humira biosimilar), Otezla, Pyzchiva (Stelara biosimilar), generic Otulfi (ustekinumab-aauz - Stelara biosimilar), and Yesintek (Stelara biosimilar).
Please select answer below:

❑ **YES –** Please answer the questions specific to the patient's age below:

i. **Age 18 or older:** Please select the requested preferred medication: ❑Enbrel 25 mg ❑Enbrel 50 mg ❑Otezla ❑generic Hulio (adalimumab-fkjp) ❑Hyrimoz ❑Pyzchiva ❑generic Otulfi (ustekinumab-aauz) ❑Yesintek

ii. **Age 6 to 17:** Please select the requested preferred medication: ❑Pyzchiva ❑generic Otulfi (ustekinumab-aauz) ❑Yesintek

iii. **Age 6 or older:** Does the prescriber agree to review the plan criteria associated with the requested preferred medication to ensure that the medication is safe and appropriate for the patient? ❑Yes ❑No

❑ **NO –** Do not switch.

❑Ulcerative colitis (UC), **please specify the medical record page number(s). PAGE(s)_____ of _____**

a. Does the prescriber agree not to exceed the FDA labeled maintenance dose of 90 mg subcutaneously every 8 weeks? ❑Yes ❑No

b. **Standard/Basic Option Patient:** Has the patient tried and failed generic Hulio (adalimumab-fkjp - Humira biosimilar), Hyrimoz (Humira biosimilar), Rinvoq, Skyrizi, Pyzchiva (Stelara biosimilar), generic Otulfi (ustekinumab-aauz - Stelara biosimilar), Yesintek (Stelara biosimilar), Tremfya, or Xeljanz/Xeljanz XR? ***Please select answer below:***

❑ **YES –Please specify the medication(s) and medical record page number(s).**

Medication(s): _____ PAGE(s)_____ of _____

❑ **NO – The patient has not tried and failed any of these medications.**

PLEASE PROCEED TO PAGE 19 FOR ADDITIONAL ULCERATIVE COLITIS RELATED QUESTIONS & OTHER DIAGNOSES

BlueCross BlueShield Federal Employee Program

STELARA
PRIOR APPROVAL REQUEST

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

PAGE 2 - PHYSICIAN COMPLETES

Patient Name: _____ DOB: _____ Patient ID: R _____

Ulcerative colitis CONTINUED:

c. **Standard/Basic Option Patient:** Would you like to switch to a preferred medication? The preferred medications are generic Hulio (adalimumab-fkjp - Humira biosimilar), Hyrimoz (Humira biosimilar), Rinvoq, Skyrizi, Pyzchiva (Stelara biosimilar), generic Otulfi (ustekinumab-aauz - Stelara biosimilar), Yesintek (Stelara biosimilar), Tremfya, and Xeljanz/Xeljanz XR. ***Please select answer below:***

❑ **YES –** Please answer the questions below:

i. Please select the requested preferred medication: ❑Rinvoq ❑Skyrizi ❑Tremfya ❑Hyrimoz ❑generic Hulio (adalimumab-fkjp) ❑Pyzchiva ❑generic Otulfi (ustekinumab-aauz) ❑Yesintek ❑ Xeljanz 5mg ❑Xeljanz 10mg ❑ Xeljanz XR 11mg ❑Xeljanz XR 22mg

ii. Does the prescriber agree to review the plan criteria associated with the requested preferred medication to ensure that the medication is safe and appropriate for the patient? ❑Yes ❑No

❑ **NO –** Do not switch.

❑ **NO –** Do not switch however the patient has a medical exception. **Please specify the medical record page number(s). PAGE(s)_____ of _____**

❑ **NO –** Do not switch however I would like to speak with a medical director to discuss the case. **Please specify the preferred date and time to contact, including the time zone, and the phone number: _____**

_____

d. **Blue Focus Patient:** This is a non-formulary medication. Please provide all formulary alternative medication(s) that have been tried and failed and specify the medical record page number(s) below:

❑**PAGE(s)_____ of _____ Formulary alternative medication(s):_____**

_____

❑ **The patient has not tried and failed any formulary alternatives.**

e. **Blue Focus Patient:** Would you like to switch to a preferred medication? The preferred medications are generic Hulio (adalimumab-fkjp - Humira biosimilar), Hyrimoz (Humira biosimilar), Pyzchiva (Stelara biosimilar), generic Otulfi (ustekinumab-aauz - Stelara Biosimilar), and Yesintek (Stelara biosimilar). ***Please select answer below:***

❑ **YES –** Please answer the questions below:

i. Please select the requested preferred medication: ❑generic Hulio (adalimumab-fkjp) ❑Hyrimoz ❑Pyzchiva ❑generic Otulfi (ustekinumab-aauz) ❑Yesintek

ii. Does the prescriber agree to review the plan criteria associated with the requested preferred medication to ensure that the medication is safe and appropriate for the patient? ❑Yes ❑No

❑ **NO –** Do not switch.

❑Other ***(please specify):*** _____