BlueCross BlueShield Federal Employee Program

STELARA
PRIOR APPROVAL REQUEST

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

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

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					

Stelara (ustekinumab)

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

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

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 4**
   ❑ **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, 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, Taltz, Tremfya, Truxima, Xeljanz/Xeljanz XR, Zymfentra.***
7. What is the patient's diagnosis?
   ❑Crohn's disease (CD)
   a. Does the patient have a diagnosis of 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. **Standard/Basic Option patient, for claims adjudicated through the pharmacy benefit:** Is this medication being requested as a change from Cimzia, Entyvio, Omvoh, or Zymfentra to allow the member access to their copay benefit? ❑Yes* ❑No
   ****If YES***, please select medication: ❑Cimzia ❑Entyvio ❑Omvoh ❑Zymfentra

PLEASE PROCEED TO PAGE 2 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 a diagnosis of 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 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 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. **Standard/Basic Option patient, <u>for claims adjudicated through the pharmacy benefit</u>:** Is this medication being requested as a change from one of the following to allow the member access to their copay benefit: Bimzelx, Cimzia, Cosentyx, Ilumya, Siliq, or Sotyktu? ❑Yes***** ❑No ****If YES***, select medication: ❑Bimzelx ❑Cimzia ❑Cosentyx ❑Ilumya ❑Siliq ❑Sotyktu

❑ Psoriatic arthritis (PsA)

a. Does the patient have a diagnosis of 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

e. **Standard/Basic Option patient, <u>for claims adjudicated through the pharmacy benefit</u>:** Is this medication being requested as a change from one of the following to allow the member access to their copay benefit: Bimzelx, Cimzia, Cosentyx, Orencia SC, or Simponi? ❑Yes***** ❑No ****If YES***, select medication: ❑Bimzelx ❑Cimzia ❑Cosentyx ❑Orencia SC ❑Simponi

PLEASE PROCEED TO <u>PAGE 3</u> FOR ADDITIONAL DIAGNOSES

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PAGE 3 - PHYSICIAN COMPLETES

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

❑ 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. **Standard/Basic Option patient, <u>for claims adjudicated through the pharmacy benefit</u>:** Is this medication being requested as a change from one of the following to allow the member access to their copay benefit: Entyvio, Omvoh, Simponi, Velsipity, Xeljanz/Xeljanz XR, Zeposia, or Zymfentra? ❑Yes***** ❑No

If YES, please select medication: ❑Entyvio ❑Omvoh ❑Simponi ❑Velsipity ❑Xeljanz/Xeljanz XR ❑Zeposia ❑Zymfentra

❑ 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					

CONTINUATION OF THERAPY (PA RENEWAL)

Stelara (ustekinumab)

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

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

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 1**
   ❑**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, 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, Taltz, Tremfya, Truxima, Xeljanz/Xeljanz XR, Zymfentra.
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
   ❑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

PLEASE PROCEED TO PAGE 4 FOR ADDITIONAL DIAGNOSES

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PAGE 5 – PHYSICIAN COMPLETES

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

❑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

❑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

❑Other ***(please specify):*** _____