SENTARA COMMUNITY PLAN
(MEDICAID)

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: Non-Preferred Ustekinumab products (PHARMACY BENEFIT ONLY)
(ustekinumab SQ therapy is Self-Administered by member)

❑ **Stelara®** (Ustekinumab)	❑ **Imuldosa™** (ustekinumab-srlf)	❑ **Otulfi®** (ustekinumab-aauz)
❑ **Pyzchiva®** (ustekinumab-ttwe	❑ **Selarsdi®** (Ustekinumab-aekn)	❑ **Steqeyma®** (Ustekinumab-stba)
❑ **Yesintek™** (Ustekinumab-kfce)		

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight (if applicable): _____ **Date weight obtained:** _____

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Recommended Dose:

Indication	Dosage:
Adults with Moderate to Severe Chronic Plaque Psoriasis	**Weight** • Less than or = 100 kg Initial (two 45 mg prefilled syringe/ 28 days) then continue with one 45 mg prefilled syringe/84 days • Great than 100 kg Two 90 mg administered prefilled syringe/ 28 days then, one 90 mg administered prefilled syringe/ 84 days
Adolescent patients (6 years or older) with Moderate to Severe Chronic Plaque Psoriasis	• <60 kg (0.75 mg/kg): Initial (two 45 mg prefilled syringe/28days) then one 45mg/84 days • ≥ 60 to ≤ 100 kg: Initial (two 45 mg prefilled syringe/ 28 days) then one 45/ 84 days • >100 kg: two 90 mg administered prefilled syringe/ 28 days, then one 90 mg/84 days
Active Psoriatic Arthritis	• <60 kg (0.75 mg/kg): Initial (two 45 mg prefilled syringe/28days) then one 45mg/84 days • ≥ 60 to ≤ 100 kg: Initial (two 45 mg prefilled syringe/ 28 days) then one 45/ 84 days • >100 kg: two 90 mg administered prefilled syringe/ 28 days, then one 90 mg/84 days
Moderately to Severe Active Crohn's Disease	• A single intravenous infusion using weight-based dosing • Up to 55 kg 260 mg (2 vials) • Greater than 55 kg to 85 kg 390 mg (3 vials) • Greater than 85 kg 520 mg (4 vials) • After initial IV dose: 90mg syringe every 56 days
Adult patient with Moderately to Severely Active Ulcerative Colitis	• A single intravenous infusion using weight-based dosing • Up to 55 kg 260 mg (2 vials) • Greater than 55 kg to 85 kg 390 mg (3 vials) • Greater than 85 kg 520 mg (4 vials) • After initial IV dose: 90mg syringe every 56 days

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

Diagnosis: Check below diagnosis that applies to qualify for approval or authorization may be delayed.

❑ **DIAGNOSIS: Active Psoriatic Arthritis**

❑ Member is 6 years or older with psoriatic arthritis

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- ❑ Member tried and failed at least **one DMARD** **(Check each tried):**

❑ methotrexate	❑ sulfasalazine	❑ azathioprine
❑ leflunomide	❑ auranofin	❑ hydroxychloroquine

- ❑ Patient has tried and failed **TWO (2)** of the following biologics:

❑ Humira®	❑ Enbrel®	❑ Infliximab

❑ DIAGNOSIS: Moderate to Severe Chronic Plaque Psoriasis

- ❑ Member is 6 years or older with moderate to severe plaque psoriasis who are candidates for phototherapy or systemic therapy
- ❑ Trial and failure of, contraindication, or adverse reaction to methotrexate
- ❑ Trial and failure of **TWO (2)** of the **PREFERRED** drugs below:

❑ Humira®	❑ Enbrel®	❑ Infliximab

DIAGNOSIS: Check diagnosis that applies.

❑ **Crohn's Disease**	❑ **Ulcerative Colitis**:

- ❑ Member has trial and failure of a compliant regimen of oral corticosteroids (budesonide 9mg daily for 8 weeks) or high dose steroids (40-60 mg prednisone) (moderate to severe CD) unless contraindicated or intravenous corticosteroids (severe and fulminant CD or failure to respond to oral corticosteroids)
- ❑ Member tried and failed **at least ONE previous 5-Aminosalicylates or immunomodulators therapy below:**

❑ methotrexate	❑ azathioprine	❑ auranofin
❑ sulfasalazine	❑ oral aminosalicylates	❑ leflunomide
❑ 6-mercaptopurine	❑ Apriso®	❑ balsalazide
❑ Pentasa®		

- ❑ Member has tried and failed both:

❑ Humira®	❑ Infliximab

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CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

❑ Induction Dose (If required) – Single IV induction dose

Authorization Criteria: To be reviewed for one-time approval under the medical benefit

- ❑ Medication will be used as induction therapy
- ❑ Medication being provided by:
- ❑ Location/site of drug administration: _____
- ❑ NPI or DEA # of administering location: _____
- ❑ Select **ONE** of the following one-time doses to be administered based on member's weight
  - ❑ ≤55 kg: 260 mg as single dose; 260 mg = 260 billable units
  - ❑ >55 kg to 85 kg: 390 mg as single dose; 390 mg = 390 billable units
  - ❑ >85 kg: 520 mg as single dose; 520 mg = 520 mg billable units

Medication being provided by Specialty Pharmacy - PropriumRx

Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.

Previous therap-ies will be verified through pharmacy paid claims or submitted chart notes.