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)
❑ **ustekinumab** (generic Stelara®)	❑ **ustekinumab-aekn** (generic Selarsdi®)	❑ **ustekinumab-ttwe** (generic Pyzchiva®)
❑ **Wezlana™** (ustekinumab-kfce)	❑ **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:** _____

(Continued on next page)

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
Pediatric 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: Adults with Active Psoriatic Arthritis**

❑ Member is has a diagnosis of moderate to severe psoriatic arthritis

(Continued on next page)

- ❑ For members with predominantly axial disease OR enthesitis, a failure of at least a 4-week trial of ONE non-steroidal anti-inflammatory drug (NSAID), unless use is contraindicated **OR**
- ❑ For members with peripheral arthritis OR dactylitis, a failure of at least a 3-month trial of ONE conventional synthetic disease-modifying anti-rheumatic drug (csDMARD) (e.g., methotrexate, azathioprine, sulfasalazine, leflunomide, hydroxychloroquine, etc.)
- ❑ Member has tried and failed **TWO (2)** of the preferred drugs below:

❑ Humira®	❑ Enbrel®	❑ Infliximab

❑ Diagnosis: Pediatric members (6 years and older) with psoriatic arthritis

- ❑ Member is 6 years or older
- ❑ Member has a diagnosis of moderate to severe active polyarticular disease
- ❑ Member has had at least a 1-month trial and failure (unless contraindicated or intolerant) of previous therapy with either oral non-steroidal anti-inflammatory drugs (NSAIDs) **OR**
- ❑ Member has a trial and failure of conventional synthetic disease-modifying anti-rheumatic drugs (csDMARDs) (e.g., methotrexate, leflunomide, sulfasalazine, etc.)
- ❑ Trial and failure of **TWO (2)** of the preferred drugs below:

❑ Humira®	❑ Enbrel®	❑ Infliximab

❑ Diagnosis: Moderate to Severe Chronic Plaque Psoriasis

- ❒ Member is 6 years or older
- ❑ Member has a diagnosis of moderate to severe plaque psoriasis who are candidates for phototherapy or systemic therapy
- ❑ Medication has been prescribed by, in consultation with, a dermatologist, rheumatologist, or other specialist in the treatment of psoriasis
- ❑ Symptoms persistent for ≥ 6 months with at least one (1) of the following:
  - ❑ Involvement of at least 3% of body surface area (BSA)
  - ❑ Psoriasis Area and Severity Index (PASI) score of 10 or greater
  - ❑ Incapacitation due to plaque location (i.e., head and neck, palms, soles, or genitalia) or with intractable pruritus
- ❑ Member did not respond adequately (or is not a candidate) to a 4 week minimum trial of topical agents (i.e., anthralin, coal tar preparations, corticosteroids, emollients, immunosuppressives, keratolytics, roflumilast, retinoic acid derivatives, and/or vitamin D analogues)
- ❑ Member did not respond adequately (or is not a candidate) to a 3 month minimum trial of at least ONE non-biologic systemic agent (i.e., immunosuppressives, retinoic acid derivatives, and/or methotrexate)
- ❑ Member did not respond adequately (or is not a candidate) to a 3 month minimum trial of phototherapy (i.e., psoralens with UVA light [PUVA] or UVB with coal tar or dithranol)

(Continued on next page)

- ❑ Trial and failure of **TWO (2)** of the preferred drugs below:

❑ Humira®	❑ Enbrel®	❑ Infliximab

❑ Diagnosis: Ulcerative Colitis

- ❑ Member has a diagnosis of moderate to severe active disease
- ❑ Member has a documented failure or ineffective response to a minimum 3-month trial of conventional therapy [aminosalicylates, corticosteroids or immunomodulators (e.g., azathioprine, 6mercaptopurine, methotrexate, etc.] at maximum tolerated doses, unless there is a contraindication or intolerance to use
- ❑ Trial and failure of **BOTH** of the preferred drugs below:

❑ Humira®	❑ Infliximab

❑ Diagnosis: Crohn's Disease

- ❑ Member has a diagnosis of moderate to severe active disease
- ❑ Member has one of the following:
  - ❒ Documented failure, contraindication, or ineffective response at maximum tolerated doses to a minimum (3) month trial of corticosteroids or immunomodulators (e.g., azathioprine, 6mercaptopurine, or methotrexate)
  - ❒ Member has evidence of high-risk disease for which corticosteroids or immunomodulators are inadequate and biologic therapy is necessary
- ❑ Trial and failure of **BOTH** of the preferred drugs below:

❑ Humira®	❑ Infliximab

❑ 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

(Continued on next page)

Medication being provided by Specialty Pharmacy - PropriumRx

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

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.*

REVISED/UPDATED/REFORMATTED: ~~8/1/2017; 8/31/2017; 12/27/2017; 8/30/2018; 11/19/2018; (Rev) 4/6/2019; 1/6/2020; 6/18/2020; 12/21/2020; 7/19/2021; 8/10/2021; 7/11/2022; 6/26/2023; 9/26/2023; 3/25/2025;~~ **10/17/2025**