Sentara Health Plans

Would you like to use electronic prior authoriztion? Consider using Surescripts, our electronic prior authorization portal at providerportal.surescripts.net/ProviderPortal/login OR fax completed prior authorization request form to 800-750-9692.

All requested data must be provided. **Incomplete forms or forms without the chart notes will be returned**

Pharmacy Coverage Guidelines are available at sentarahealthplans.com/en/providers/authorizations/prescription-drugs

Ustekinumab (Medicare)

REQUIRED: Office notes, labs, and medical testing relevant to request showing medical justification to support diagnosis

Member Information

Member Name (first & last):	Date of Birth:	Gender: ☐Male ☐Female	Height:
Member ID:	City:	State:	Weight:

Prescribing Provider Information

Requestor's Name:	Requestor's Phone Number:	Requestor's Fax Number:	
Provider Name (first & last):	Specialty	NPI:	DEA:
Office Address:	City:	State:	Zip Code:
Office Contact:	Office Phone:	Office Fax:	

Dispensing Provider/Pharmacy Information

Place of Administration:	☐Self-Administered ☐Physician's Office ☐Home ☐Home Infusion Center ☐Outpatient Infusion Center Name: _____

Agency NPI:	Agency Name:	Agency Phone Number:
Agency Address		Agency Fax Number:
City:	State:	Zip:

Dispensing Location:	☐Retail Pharmacy ☐Mail Order ☐Physician's Office ☐Specialty Pharmacy ☐Other

Pharmacy Name:	Pharmacy Phone:	Pharmacy Fax:
Pharmacy NPI:		

Requested Medication Information

Medication request is NOT for an FDA approved, or compendia-supported diagnosis (check one): ☐Yes ☐No	Diagnosis:	ICD-10 Code:
Are there any contraindications to formulary medications? If yes, please specify:	Is this a New Request or Continuation of Therapy: ☐New, start date: __/__/_____ ☐Continuation, date of last treatment: __/__/_____	
Directions for Use:	Strength:	Dosage Form
	Duration:	Quantity: / Days Supply:

What medication(s) has the member tried and failed for this diagnosis? Please specify below including duration of treatment.

Turn-Around Time for Review:

☐Standard ☐Urgent: Waiting standard time for decision could seriously harm life, health, or ability to regain maximum function, you can ask for an expedited decision.

Signature: _____

Sentara Health Plans Member First Name: _____ Member Last Name: _____

Member ID: _____ Member Date of Birth: _____

Clinical Information:

** Indicate questions that are required to be answered*

Q1. For Reauthorization: Has the member responded positively to therapy as determined by the prescribing physician?

☐ Yes ☐ No

Q2. Please select applicable diagnosis: *

☐ Crohn's Disease (CD)
☐ Plaque Psoriasis (PsO)
☐ Psoriatic Arthritis (PsA)
☐ Ulcerative Colitis (UC)
☐ Other

Q3. For all diagnoses: Will the medication be used concomitantly with other biologics or targeted synthetic DMARDs?

☐ Yes ☐ No

Q4. For all diagnoses: Has the medication been prescribed by or in consultation with one of the following:

☐ PsA: Rheumatologist or dermatologist
☐ PsO: Dermatologist
☐ UC/CD: Gastroenterologist
☐ None of the above

Q5. For all diagnoses: If requesting any other product than Selarsdi or Yesintek, has documentation been submitted with clinical rationale to show why the member cannot use the preferred biosimilar formulations of Ustekinumab (Selarsdi and Yesintek)?

☐ Yes ☐ No

Q6. For all diagnoses: Does the member have moderately to severely active disease?

☐ Yes ☐ No

Q7. For CD/UC: Has the member received a single IV loading dose within two months of initiating therapy with the requested medication?

☐ Yes ☐ No

Q8. For CD: Does the member have evidence of large or deep ulcers, strictures, or extensive areas of disease and/or evidence of stricturing, penetrating, or perianal disease on endoscopy?

☐ Yes ☐ No

Q9. For UC: Which of the following does the member have:

Sentara Health Plans

Member First Name: _____ Member Last Name: _____

Member ID: _____ Member Date of Birth: _____

- ☐ Member presents with frequent, bloody stools that occur 6 or more times daily or frequent and heavy rectal bleeding
- ☐ Member has severe inflammation or ulcers as visualized on endoscopy
- ☐ None of the above

Q10. For PsA: Has documentation been sent showing the presence of at least one of the following: actively inflamed joints, dactylitis, enthesitis, axial disease, active skin or nail involvement, or extraarticular manifestations such as uveitis or inflammatory bowel disease (IBD)?

☐ Yes ☐ No