SENTARA HEALTH PLANS

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 may be delayed.**

Drug Requested: Stelara® SQ & IV (ustekinumab) For CD & UC (Pharmacy) (Preferred)

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:** _____

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

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

Diagnosis: _____ **ICD Code:** _____

Weight: _____ **Date:** _____

NOTE: Sentara Health Plans considers the use of concomitant therapy with more than one biologic immunomodulator (e.g., Dupixent, Entyvio, Humira, Rinvoq, Stelara) prescribed for the same or different indications to be experimental and investigational. Safety and efficacy of these combinations has **NOT** been established and will **NOT** be permitted.

ATTENTION: Stelara IV induction (loading dose) for treatment of Crohn's disease & Ulcerative colitis can only be billed under the **MEDICAL BENEFIT**. NDC: 57894-0054-27; J3358; 260 mg = 260 billable units, 390 mg = 390 billable units, 520 mg = 520 mg billable units

Adult Dosing:

- **Induction IV: NDC: 57894-0054-27 – Stelara IV 130 mg/26 mL vial – J3358**
  - ❑ ≤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
- **Maintenance SubQ: NDC: 57894-0061-03 – Stelara SQ 90 mg/mL prefilled syringe**
  - ❑ 90 mg every 8 weeks; beginning 8 weeks after administration of IV induction dose

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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.

❑ **Maintenance Dose – 90 mg every 8 weeks**

Authorization Criteria: To be reviewed for approval under the pharmacy benefit

- ❑ Member has **ONE** of the following diagnoses
  - ❑ Moderate-to-severe active **crohn's disease**
  - ❑ Moderate-to-severe active **ulcerative colitis**
- ❑ Prescribed by or in consultation with a **Gastroenterologist**
- ❑ Member meets **ONE** of the following:
  - ❑ Member has tried and failed budesonide or high dose steroids (40-60 mg prednisone)
  - ❑ Member has tried and failed at least **ONE** of the following **DMARD** therapies for at least **three (3) months**
    - ❑ 5-aminosalicylates (balsalazide, olsalazine, sulfasalazine)
    - ❑ oral mesalamine (Apriso, Asacol/HD, Delzicol, Lialda, Pentasa)

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 a Specialty Pharmacy – Proprium Rx

*****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.****

***Approved by Pharmacy and Therapeutics Committee:** ~~1/21/2010; 7/22/2016~~; 9/16/2022
REVISED/UPDATED: ~~10/28/2014; 12/2/2014; 1/15/2015; 5/22/2015~~; ~~12/29/2015~~; ~~7/22/2016~~; ~~8/11/2016~~; ~~9/22/2016~~; ~~12/16/2016~~; ~~1/31/2017~~; ~~7/24/2017~~; ~~9/1/2017~~; ~~10/10/2017~~; ~~12/16/2017~~; ~~3/31/2018~~;~~11/23/2018 (Reformatted)~~ ~~9/18/2019~~; ~~11/20/2019~~, ~~3/31/2020~~; ~~10/4/2022~~; ~~12/30/2022~~; **5/26/2023**