Stelara® (ustekinumab)

MDwise

Medication Request Form (MRF) for Healthy Indiana Plan (HIP) and Hoosier Healthwise (HHW)
FAX TO: (858) 790-7100
c/o MedImpact Healthcare Systems, Inc.
Attn: Prior Authorization Department
10181 Scripps Gateway Court, San Diego, CA 92131 - Phone: 1-800-788-2949

Instructions:
This form is to be used by participating providers to obtain coverage for the drug listed above which requires *prior authorization*. Please complete this form and fax it to *Med**Impact*** Healthcare Systems, Inc. at (858) 790-7100. If you have any questions regarding this process, please contact Med***Impact***'s Customer Service at (800) 788-2949.

Member/Provider Information:

MDwise Member's Name:	**Provider's Name:**
MDwise Member's ID #:	**Provider's Specialty:**
MDwise Member's DOB (mm-dd-yy):	**Provider's DEA #:** | **Provider's NPI #:**
Pharmacy used by MDwise Member:	**Provider's Telephone Number/Contact Name (xxx-xxx-xxxx):**
Pharmacy Telephone Number (xxx-xxx-xxxx):	**Provider's Fax Number (xxx-xxx-xxxx):**

Clinical Information:

Requested Drug: ☐ **Stelara®**	**Dose and Quantity Requested:**
Patient's Current Weight: _____**kg**	**Date weight was measured (mm-dd-yy):** _____
Date Requested:	**Length of Treatment** (*please be specific*)**:**

Documentation of Medical Necessity (please check all that apply, completing all applicable sections):

1. Does the patient have a diagnosis of ***psoriatic arthritis***? ○ Yes ○ No

AND

Is this for initial therapy (i.e., is the patient naïve to this medication)? ○ Yes ○ No

If no, has the patient experienced or maintained ≥20% improvement in tender or swollen joint count while on this medication? ○ Yes ○ No

AND

Has this treatment been prescribed by or in consultation with a rheumatologist or a dermatologist? ○ Yes ○ No

AND

Has the patient tried at least **ONE** of the following DMARDs?

methotrexate	○ Yes	○ No	**If yes**, describe the response/reaction to that medication below:
leflunomide	○ Yes	○ No	_____
hydroxychloroquine	○ Yes	○ No	_____
sulfasalazine	○ Yes	○ No	_____

AND

Has the patient tried at least **TWO** of the following preferred agents?

Cimzia®	○ Yes	○ No	Simponi®	○ Yes	○ No
Cosentyx®	○ Yes	○ No	Xeljanz/ Xeljanz XR®	○ Yes	○ No
Enbrel®	○ Yes	○ No	**If yes**, describe the response/reaction to the medications below:		
Orencia®	○ Yes	○ No	_____		
Otezla®	○ Yes	○ No	_____		

2. Does the patient have a diagnosis of ***moderate to severe*** *plaque psoriasis*? ○ Yes ○ No

AND

Is this for initial therapy (i.e., is patient naïve to this medication)? ○ Yes ○ No

If no, did the patient achieve or maintain clear or minimal disease or experience a decrease in PASI (Psoriasis Area and Severity Index) of at least 50% while on therapy? ○ Yes ○ No

AND

Does the plaque psoriasis involve at least 10% body surface area (BSA) or are there psoriatic lesions affecting the face, hands, feet, or genital area? ○ Yes ○ No

AND

Has this medication been prescribed by or in consultation with a dermatologist? ○ Yes ○ No

AND

Has the patient tried at least **ONE** of the following preferred therapies?

PUVA (Phototherapy Ultraviolet Light A) or UVB (Ultraviolet Light B) ○ Yes ○ No

topical corticosteroids ○ Yes ○ No

acitretin ○ Yes ○ No

calcipotriene ○ Yes ○ No

cyclosporine ○ Yes ○ No

methotrexate ○ Yes ○ No

If yes, describe the response/reaction to that treatment below:

_____

_____

AND

Has the patient tried at least **TWO** of the following preferred agents?

Cimzia® ○ Yes ○ No

Cosentyx® ○ Yes ○ No

Enbrel® ○ Yes ○ No

Otezla® ○ Yes ○ No

If yes, describe the response/reaction to the medications below:

_____

_____

3. Does the patient have a diagnosis of ***moderately to severely active*** Crohn's disease? ○ Yes ○ No

AND

Is this for initial therapy (i.e., is patient naïve to this medication)? ○ Yes ○ No

If no, has the patient experienced symptomatic improvement while on therapy? ○ Yes ○ No

AND

Has this medication been prescribed by or in consultation with a gastroenterologist? ○ Yes ○ No

AND

Has the patient tried at least **ONE** of the following agents?

corticosteroids ○ Yes ○ No

azathioprine ○ Yes ○ No

mercaptopurine ○ Yes ○ No

methotrexate ○ Yes ○ No

mesalamine ○ Yes ○ No

If yes, describe the response/reaction to that medication below:

_____

_____

_____

_____

AND

Has the patient tried or have a contraindication to the following preferred formulary agent?

Cimzia ○ Yes ○ No

If yes, describe the response/reaction or CI to that medication below:

_____