South Dakota Department of Social Services

Please note: All information below is required to process this request.
**Fax to 1-844-403-1029**
**Mon-Sat: 7am to 7pm Central**

# Stelara® Prior Authorization Request Form (Page 1 of 2)

**DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED**

| Member Information (required) | | | Provider Information (required) | | |
|---|---|---|---|---|---|
| Member Name: | | | Provider Name: | | |
| Insurance ID#: | | | NPI#: | Specialty: | |
| Date of Birth: | | | Office Phone: | | |
| Street Address: | | | Office Fax: | | |
| City: | State: | Zip: | Office Street Address: | | |
| Phone: | | | City: | State: | Zip: |

## Medication Information (required)

| Medication Name: | Strength: | Dosage Form: |
|---|---|---|
| ❑ Check if requesting **brand** | Directions for Use: | |
| ❑ Check if request is for **continuation of therapy** | | |

## Clinical Information (required)

**Select the diagnosis below:**

- ❑ Active psoriatic arthritis (PsA)
- ❑ Moderate to severe chronic plaque psoriasis
- ❑ Moderately to severely active Crohn's disease
- ❑ Moderately to severely active ulcerative colitis
- ❑ Other diagnosis: _____ ICD-10 Code(s): _____

**Clinical information:**

Select if the requested medication is prescribed by or in consultation with one of the following specialists:
❑ Dermatologist ❑ Gastroenterologist ❑ Rheumatologist ❑ Other _____

Will the requested medication be used in combination with another biologic agent? ❑ **Yes** ❑ **No**

**For active psoriatic arthritis (PsA), also answer the following:**

Has the patient had an inadequate response to, intolerance to, or contraindication to methotrexate? ❑ **Yes** ❑ **No**

**For moderate to severe chronic plaque psoriasis, also answer the following:**

Has the patient had an inadequate response to, intolerance to, or contraindication to conventional therapy with at least one of the following: phototherapy or one or more oral systemic treatments (i.e., methotrexate, calcipotriene, cyclosporine, acitretin, sulfasalazine, tazarotene, corticosteroid)? ❑ **Yes** ❑ **No** List _____

**For moderately to severely active Crohn's disease, also answer the following:**

Has the patient had an inadequate response to, intolerance to, or contraindication to one or conventional therapy (e.g., azathioprine, mercaptopurine, methotrexate, corticosteroids)? ❑ **Yes** ❑ **No** List _____

**For moderately to severely active Ulcerative Colitis, also answer the following:**

Has the patient had an inadequate response to, intolerance to, or contraindication to one or more conventional therapy (e.g., corticosteroids, mesalamine, balsalazide, olsalazine, azathioprine, mercaptopurine, methotrexate)? ❑ **Yes** ❑ **No**

List _____

**Quantity limit requests:**

What is the quantity requested per TREATMENT? _____ syringe every _____ weeks

**What is the reason for exceeding the plan limitations?**

- ❑ Titration or loading dose purposes
- ❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
- ❑ Requested strength/dose is not commercially available
- ❑ Other: _____

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**Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?**

_____

_____

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-855-401-4262.
This form may be used for non-urgent requests and faxed to 1-844-403-1029.