Independence

Today's date: _____ **Intended date of injection:** _____

Prior Authorization Form – Stelara®

Buy-and-bill requests for this drug should be submitted through NaviNet®.

ONLY COMPLETED REQUESTS WILL BE REVIEWED.

Check one: ☐ New start ☐ Continued treatment

Patient information (please print)		Physician information (please print)	
Patient name		Prescribing physician	
Address		Office address	
City, state, ZIP		City, state, ZIP	
Patient telephone #		Office contact	
Patient ID		Office telephone #	
Date of birth	Weight	Fax #	NPI

This drug will be delivered to the requesting physician for the formulation selected below:
Prefilled syringe: _____ 45mg _____ 90mg or **Vial:** _____ 45mg _____ 130mg

**** A copy of the prescription must accompany the medication request for delivery.****

1) Diagnosis for drug requested (must include ICD-10): _____

2) Patient medical information

For Crohn's disease or ulcerative colitis only

a. Does the patient have a documented history of failure, contraindication, or intolerance to at least one of the following? Check all that apply and list the drug(s) on the line provided below: ☐ Yes ☐ No
- ☐ Immunomodulators (e.g., azathioprine, 6-mercaptopurine, methotrexate); _____
- ☐ Corticosteroids (e.g., budesonide [Entocort® EC], prednisone, hydrocortisone, methylprednisolone); _____
- ☐ Biologic therapy (e.g., TNF blockers [including certolizumab {Cimzia®}, adalimumab {Humira®}, infliximab {Remicade®}], or vedolizumab (Entyvio®); _____

b. Had/Will the patient receive one intravenous infusion before switching to subcutaneous injections? ☐ Yes ☐ No

For plaque psoriasis only

a. Is the patient's chronic plaque psoriasis classified as moderate-to-severe? ☐ Yes ☐ No

b. Does the patient have a documented history of failure, contraindication, or intolerance to any of the following? ☐ Yes ☐ No
Check all that apply and list the drug(s) on the line provided below:
- ☐ Topical steroids available by prescription only; _____
- ☐ Topical nonsteroids available by prescription only (e.g., topical calcipotriene [Dovonex®], topical anthralin, topical retinoids [Tazorac®]); _____
- ☐ Topical immunomodulators (e.g., pimecrolimus [Elidel®], tacrolimus [Protopic®]); _____
- ☐ Methotrexate; _____
- ☐ Oral retinoids (e.g., Soriatane®); _____
- ☐ Cyclosporine (e.g., Neoral, Gengraf); _____

For psoriatic arthritis only

a. Does the patient have a documented history of failure, contraindication, or intolerance to any disease-modifying antirheumatic drug (DMARD) such as, but not limited to, sulfasalazine, azathioprine, hydroxychloroquine, cyclosporine, methotrexate, or anti-tumor necrosis factor agents? ☐ Yes ☐ No
If yes, list drug(s): _____

3) Prescription information

Quantity _____ refill x _____ month(s)

Instructions (include dose) _____ every _____ day(s)/ week(s)/ month(s)

Physician's signature _____

Please fax this completed form to 215-761-9580.

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