Pharmacy Prior Authorization

AETNA BETTER HEALTH ILLINOIS FAMILY HEALTH PLAN (MEDICAID)

Stelara (Medicaid)

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Aetna Better Health Illinois at **1-844-242-0908**.
When conditions are met, we will authorize the coverage of Stelara (Medicaid).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name *(please circle)*

Stelara

Other, please specify_____

Quantity _____ Frequency _____ Strength _____

Route of Administration _____ Expected Length of therapy _____

Patient Information

Patient Name: _____

Patient ID: _____

Patient Group No.: _____

Patient DOB: _____

Patient Phone: _____

Prescribing Physician

Physician Name: _____

Specialty: _____ NPI Number: _____

Physician Fax: _____ Physician Phone: _____

Physician Address: _____ City, State, Zip: _____

Diagnosis:_____ ICD Code:_____

Please circle the appropriate answer for each question.

1. Has this plan authorized Stelara in the past for this patient (i.e., previous authorization is on file under this plan)? Y N

   [If no, skip to question 6.]

2. Does the patient have a diagnosis of Crohn's disease? Y N

   [If no, skip to question 4.]

3. Is the patient in remission without requiring more than 5mg of prednisone daily? Y N

   [No further questions.]

4. Has the patient had at least a 20% improvement in symptoms? Y N

   [If no, then no further questions.]

5. Does the patient weigh more than 100kg or 220 pounds? Y N

   [No further questions.]

6. Does the patient have a diagnosis of plaque psoriasis? Y N

   [If no, skip to question 13.]

7. Does the patient have more than 10% of body surface area involvement with plaque psoriasis or has a PASI score of more than 10? Y N

   [If no, then no further questions.]

8. Has the patient failed standard topical therapies? Y N

   List topical therapies tried:

   _____

   [If no, then no further questions.]

9. Has the patient tried and had an insufficient response to phototherapy (UVB or PUVA) or is unable to receive phototherapy? Y N

   If yes, please provide rationale:_____

   [If no, then no further questions.]

10. Has the patient had failure to an adequate trial (3 months) of methotrexate or cyclosporine? Y N

    [If yes, then skip to question12.]

11. Does the patient have a contraindication methotrexate and cyclosporine? Y N

    If yes, please document contraindications:

    _____

    [If no, then no further questions.]

12. Does the plaque psoriasis have a significant impact on physical, psychological, or social wellbeing? Y N

[If no, then no further questions.]

[If yes, skip to question 27.]

13. Does the patient have a diagnosis of psoriatic arthritis (PsA)? Y N

[If no, then skip to question 22.]

14. Does the patient have primarily axial disease (involving the spine) or active enthesitis/dactylitis? Y N

[If no, skip to question 16.]

15. Has the patient tried an adequate trial (3 months) with at least 2 different NSAIDs and had inadequate response? Y N

If yes, please list medications tried:_____

[If yes, then skip to question 20.]

[If no, then skip to question 21.]

16. Does the patient have active psoriatic arthritis? Y N

[If no, then no further questions.]

17. Has the patient had failure to an adequate trial (3 months) of methotrexate? Y N

[If yes, skip to question 20.]

18. Does the patient have a contraindication to methotrexate? Y N

If yes, please document contraindication:_____

[If no, then no further questions]

19. Has the patient had failure to an adequate (3months) of sulfasalazine or leflunomide? Y N

[If no, then no further questions.]

20. Is the patient currently on or will continue taking an NSAID with requested medication? Y N

[If yes, then skip to question 27.]

21. Does the patient have contraindications to NSAIDs? Y N

If yes, please document contraindication:_____

[If yes, then skip to 27.]

[If no, then no further questions.]

22. Does the patient have a diagnosis of Crohn's Disease? Y N

[If no, then no further questions.]

23. Has the patient had inadequate response or intolerable side effects to IV corticosteroids after 7-10 days or oral prednisone (dosed at 40mg or more per day) for 30 days)? Y N

[If yes, skip to question 27.]

24. Does the patient have steroid-dependent Crohn's disease as evidenced by one of the following: A) Patient had a relapse within three months of stopping corticosteroids; OR B) Patient is unable to taper steroids to an acceptable dose after 3 months without having symptom recurrence? Y N

[If no, then no further questions.]

25. Has the patient had failure to an adequate trial (3 months) of azathioprine (AZA), mercaptopurine (6-mp) or injectable methotrexate? Y N

[If yes, skip to question 27.]

26. Does the patient have a contraindication to all of the following: azathioprine (AZA), injectable methotrexate and mercaptopurine (6-mp)? Y N

If yes, please document contraindication(s):

_____

[If no, then no further questions]

27. Has the patient had a trial and failure of at least one formulary anti-TNF (tumor necrosis factor inhibitor)? Y N

[If no, then no further questions]

28. Is the patient at least 18 years of age? Y N

[If no, then no further questions.]

29. Is Stelara being prescribed by, or in consultation with a specialist, based on indication (rheumatologist or dermatologist)? Y N

[If no, then no further questions.]

30. Has the patient been screened for latent tuberculosis (TB) and hepatitis B? Y N

    [If no, then no further questions.]

31. Does the patient have an active infection (including Hepatitis B and/or tuberculosis (TB)? Y N

    [If no, skip to question 33.]

32. Is the patient currently receiving or has completed treatment for latent TB infection or Hepatitis B? Y N

    [If no, then no further questions.]

33. Does the patient weigh more than 100kg or 220 pounds? Y N

Comments:

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature Date