

Individual and Family Plans

# **Stelara**

Fax back to: (833) 605-4407 Phone: (215) 991-4300

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process,

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Patient Name:	Prescriber Name:	
Member Number:	Fax: Phone:	
Date of Birth:	Office Contact:	
Line of Business: □ Exchange - PA	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name	e (if applicable):
REQUEST FOR EXPEDITED REVIEW: By checking this be the enrollee or the enrollee's ability to regain maximum fu		v timeframe may seriously jeopardize the life or health of
Drug Name:		
Strength:		
Directions / SIG:		
Please attach any pertinent medical history including labs and information for this member that may support approval.  Please answer the following questions and sign.		
Q1. Is this a request for continuati	on?	
☐ Yes	□No	
Q2. Is there documentation of imp	provement in symptoms?	
☐ Yes	□No	
Q3. Is Stelara being prescribed by gastroenterologist?	or in consultation with a dermato	ologist, rheumatologist, or
☐ Yes	□ No	
Q4. Is there documentation of tub infection OR positive for latent tube receiving treatment for latent tube	erculosis with documentation that	
☐Yes	□ No	
Q5. Is the patient being treated wi	th live vaccines?	

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Patient Name:	Prescriber Name:	
☐ Yes	□ No	
Q6. Does the patient have any active, serious infections?		
☐ Yes	□ No	
Q7. Does the patient have a confirmed diagnosis of moderate to severe plaque psoriasis and is a candidate for phototherapy or systemic therapy?		
☐ Yes	□ No	
Q8. Is the patient 6 to 17 years of age?		
☐ Yes	□ No	
Q9. Is there documentation of an inadequate response, intolerance, or contraindication to Enbrel?		
☐ Yes	□ No	
Q10. Is the patient 18 years of age or older?		
☐ Yes	□ No	
Q11. Is there documentation of an inadequate response, intolerance, or contraindication to 2 of the following: Enbrel, Humira, Skyrizi, Otezla?		
☐ Yes	□ No	
Q12. Does the patient have a confirmed diagnosis of active psoriatic arthritis?		
☐ Yes	□ No	
Q13. Is the patient 6 years of age or older?		
☐ Yes	□ No	

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O14. Is there documentation of an inadequate response, intolerance, or contraindication to two of the following: Enbrel, Humira, Xeljanz, Xeljanz XR, Otezla, Skyrizi?  ☐ Yes ☐ No  Q15. Does the patient have a confirmed diagnosis of moderately to severely active Crohn's disease?  ☐ Yes ☐ No  Q16. Is the patient 18 years of age or older?  ☐ Yes ☐ No  Q17. Is there documentation of an inadequate response, intolerance, or contraindication to Humira and Skyrizi?  ☐ Yes ☐ No  Q18. Does the patient have a confirmed diagnosis of moderately to severely active Ulcerative Colitis?  ☐ Yes ☐ No  Q19. Is the patient 18 years of age or older?  ☐ Yes ☐ No  Q20. Is there documentation of an inadequate response, intolerance, or contraindication to Humira and Xeljanz or Xeljanz XR?	Patient Name:	Prescriber Name:	
Q15. Does the patient have a confirmed diagnosis of moderately to severely active Crohn's disease?    Yes	· · · · · · · · · · · · · · · · · · ·		
disease?  Yes   No   No    Q16. Is the patient 18 years of age or older?  Yes   No   No    Q17. Is there documentation of an inadequate response, intolerance, or contraindication to Humira and Skyrizi?  Yes   No   No    Q18. Does the patient have a confirmed diagnosis of moderately to severely active Ulcerative Colitis?  Yes   No   No    Q19. Is the patient 18 years of age or older?  Yes   No   No    Q20. Is there documentation of an inadequate response, intolerance, or contraindication to	☐ Yes	□ No	
Q16. Is the patient 18 years of age or older?    Yes	l		
☐ Yes ☐ No   Q17. Is there documentation of an inadequate response, intolerance, or contraindication to Humira and Skyrizi? ☐ No   ☐ Yes ☐ No   Q18. Does the patient have a confirmed diagnosis of moderately to severely active Ulcerative Colitis? ☐ No   ☐ Yes ☐ No   Q19. Is the patient 18 years of age or older? ☐ No   ☐ Yes ☐ No   Q20. Is there documentation of an inadequate response, intolerance, or contraindication to	☐ Yes	□ No	
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Q18. Does the patient have a confirmed diagnosis of moderately to severely active Ulcerative Colitis?    Yes	· · · · · · · · · · · · · · · · · · ·		
Colitis?  ☐ Yes ☐ No  Q19. Is the patient 18 years of age or older?  ☐ Yes ☐ No  Q20. Is there documentation of an inadequate response, intolerance, or contraindication to	☐ Yes	□ No	
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· · ·	☐ Yes	□ No	
	· · · ·		
☐ Yes ☐ No	□Yes	□ No	
Q21. Additional Information:	Q21. Additional Information:		

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Patient Name:	Prescriber Name:
Prescriber Signature	Date
	2024 Prior Authorization Request