



Send completed form to:
 Peach State Health Plan Pharmacy Department
 Fax: 1-866-374-1579

Stelara

Prior Authorization Request

This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form toll-free to Peach State Health Plan at 1-866-374-1579.** If you have questions regarding the prior authorization, eligibility, drug copay or medication delivery; please contact Peach State Health Plan at 1-800-514-0083 option # 2.

Patient Name: _____ **Date:** _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____
Physician Office Address: _____

1. What drug is being prescribed? Stelara, Dose: _____ Frequency: _____ Other _____
2. What is the diagnosis?
 Psoriasis
 Other _____
3. What is the patient's age? _____ years
4. Has the diagnosis been made by a dermatologist? Yes No
5. Is Stelara being prescribed by a dermatologist? Yes No
6. Does the patient have negative tuberculosis (TB) test? Yes No
7. Has active TB been ruled out via negative chest x-ray? Yes No
8. Was chest x-ray taken within last 12 months? Yes No
9. Does the patient have history of or high risk for systemic malignancy? Yes No
10. Does the patient have any signs of new or active infection? Yes No
11. Is psoriasis moderately to severely active? Yes No
12. What is the percentage of body surface area (BSA) affected? _____ %BSA
13. Does the patient's psoriasis involve palms, soles, face and neck, body folds, or genitalia?
 Yes No
14. Has the patient had trials of **ALL** three of the following therapies for 3 consecutive months?
 Yes (*Indicate therapies tried*) No **If No, skip to # 17*
 Topical treatment (calcipotriene, medium to high potency corticosteroids, tazarotene, coal tar preparations, anthralin)
 Phototherapy
 One systemic therapy (methotrexate, thioguanine, cyclosporine, acitretin)

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Patient Name: _____ Patients Date of Birth: _____
Patients ID : _____

15. Did the patient have an inadequate response to the above therapies (*referring to therapies in # 14*)?
 Yes No
16. Was the patient adherent to each of the prescribed therapies (*referring to therapies in # 14*)?
 Yes No *If Yes, **Document last trial of conventional therapy:** _____
17. Is the patient **contraindicated or intolerant** to the above therapies (*referring to therapies in # 14*)?
 Yes No *If Yes, **Document last trial of conventional therapy, or contraindication:**

18. Has the patient previously received a biologic therapy for psoriasis? (i.e. Amevive, Enbrel, Humira, or Remicade) Yes No *If No, skip to # 22
19. Did the patient have an inadequate response to previous biologic therapy? (i.e. Amevive, Enbrel, Humira, or Remicade) Yes No *If No, skip to # 21
20. Was the patient adherent to previous biologic therapy? (i.e. Amevive, Enbrel, Humira, or Remicade)
 Yes No *If Yes, **Document last trial of biologic therapy:** _____
21. Was the patient intolerant to previous biologic therapy? (i.e. Amevive, Enbrel, Humira, or Remicade)
 Yes No *If Yes, **Document last trial of biologic therapy:** _____
22. Is the patient currently receiving **Stelara** therapy? Yes No *If No, no further questions

Only answer below questions if patient is currently receiving Stelara therapy

23. Has the patient demonstrated positive therapeutic response from initial course of therapy or stabilization of disease symptoms with subsequent therapy? Yes No
24. Has the patient developed any type of malignancy? Yes No
25. Will Stelara be administered every 12 weeks? Yes No

****NOTE: We can NOT make a decision without documentation - Thank You****

Information given on this form is accurate as of this date:

X _____
Prescriber or Authorized Signature **Date (mm/dd/yy)**

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