



**STELARA® (ustekinumab) Prior Authorization/Prescription/Patient Enrollment Form**

Complete form in its entirety and fax to number listed below

**1 PATIENT INFORMATION**

Last Name		First Name		Middle Initial	
Date of Birth	Sex M <input type="checkbox"/> F <input type="checkbox"/>	Medicaid ID #			
Allergies: <input type="checkbox"/> NKA or _____					
Street Address		City			
State	County	Zip Code			
Home Phone		Cell Phone			
Parent/Guardian		Day Telephone		Night Telephone	
Emergency Contact		Relationship		Telephone	

**2 PRESCRIBER INFORMATION**

Prescriber's Name		NPI Number		DEA Number	
Telephone Number		Fax Number		Hospital/Clinic Name	
Street Address		City			
State	County	Zip Code			
Contact Person at Office		Prescriber Specialty			



Goold Health Systems

**Fax Completed Form to:**

Fax Number: 800-218-3221  
Phone Number: 866-843-3604

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**Department of Vermont Health Access  
STELARA® (ustekinumab)  
PRIOR AUTHORIZATION REQUEST**

Patient Diagnosis:  Plaque Psoriasis  Psoriatic Arthritis

Patient Weight: \_\_\_\_\_ (kg)

If requesting prescriber is not a Dermatologist or Rheumatologist, has one been consulted on this case?  Yes  No

Specialist name: \_\_\_\_\_ Specialist Type: \_\_\_\_\_

Initial Request (please complete remainder of form below)

Subsequent Request: Response/tolerability to Stelara: \_\_\_\_\_

Please explain outcomes of therapy with Enbrel and/or Humira (DVHA preferred products):  
Therapy (and dates) \_\_\_\_\_ Reason for discontinuation \_\_\_\_\_

List previous medications/therapies tried and failed for this condition:  
(include oral, injectable, topical, phototherapy etc.)  
Therapy (and dates) \_\_\_\_\_ Reason for discontinuation \_\_\_\_\_

Prescriber Additional Comments: \_\_\_\_\_

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**PRESCRIPTION**

**Dosage Form and Quantity:** (90 mg dose only permitted if patient > 100 kg)

Stelara 45 mg/0.5 ml prefilled syringe      Dispense Quantity: 0.5 ml

Stelara 90 mg/1 ml prefilled syringe      Dispense Quantity: 1 ml

Sig: Dose/Route/Frequency: \_\_\_\_\_

Refill X: \_\_\_\_\_

Note: Dosed as initial dose, then 4 weeks later, then every 12 weeks.

Deliver product to:  Patient's home  MD office  Clinic

Prescriber's Signature: \_\_\_\_\_ Date: \_\_\_\_\_