VERMONT

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 ☐ F ☐	Medicaid ID #

Allergies: ☐ 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

briovaRx™

catamaran™ stay well ahead

Fax Completed Form to:

Fax Number: 800-218-3221

Phone Number: 866-843-3604

3 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:

4 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

or

☐ 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:** _____