AvMed

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-305-671-0200**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: Stelara® SQ (ustekinumab) **For PsA & PsO (Pharmacy) (Preferred)**

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member AvMed #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight: _____ **Date:** _____

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied. **Check the diagnosis below that applies.**

❑ **Diagnosis: Active Psoriatic Arthritis**

Dosing: SubQ: 45 mg at 0 and 4 weeks; then every 12 weeks thereafter. **NOTE:** When used for psoriatic arthritis, may be administered alone or in combination with methotrexate.

Coexistent psoriatic arthritis and moderate-to-severe plaque psoriasis in member's >100 kg: Initial and maintenance: 90 mg at 0 and 4 weeks; then every 12 weeks thereafter.

- ❑ Member is ≥ 6 years old and has a diagnosis of active **psoriatic arthritis**
- ❑ Prescribed by or in consultation with a **Rheumatologist**

(Continued on next page)

- ❑ Member tried and failed at least **one DMARD** for at least **three (3) months** **(check each tried below):**

❑ methotrexate	❑ azathioprine	❑ hydroxychloroquine
❑ sulfasalazine	❑ leflunomide	❑ auranofin
❑ Other: _____		

❑ Diagnosis: Moderate-to-Severe Plaque Psoriasis

Dosing: SubQ: ≤100 kg: 45 mg at 0 and 4 weeks; then every 12 weeks thereafter. >100 kg: 90 mg at 0 and 4 weeks; then every 12 weeks thereafter. **NOTE:** Doses of 45 mg given to patient's >100 kg were also efficacious; however, 90 mg is the recommended dose in these patients due to greater efficacy

- ❑ Member is ≥ 6 years old and has a diagnosis of moderate-to-severe **plaque psoriasis**
- ❑ Prescribed by or in consultation with a **Dermatologist**
- ❑ Member tried and failed at least **ONE (1)** of either **Phototherapy or Alternative Systemic Therapy** for at least **three (3) months** **(check each tried below)**:

❑ **Phototherapy:** ❑ **UV Light Therapy** ❑ NB UV-B ❑ PUVA	❑ **Alternative Systemic Therapy:** ❑ **Oral Medications** ❑ acitretin ❑ methotrexate ❑ cyclosporine

Medication being provided by a Specialty Pharmacy - PropriumRx

*****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.*****

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****

***Approved by Pharmacy and Therapeutics Committee:** ~~1/21/2010; 7/22/2016;~~ **9/16/2022**
REVISED/UPDATED: ~~10/28/2014; 12/2/2014; 1/15/2015; 5/22/2015; 12/29/2015; 7/22/2016; 8/11/2016; 9/22/2016; 12/16/2016; 1/31/2017; 7/24/2017; 9/1/2017; 10/10/2017; 12/16/2017; 3/31/2018;11/23/2018 (Reformatted) 9/18/2019; 11/20/2019, 3/31/2020; 10/4/2022; 12/30/2022;~~ **10/30/2023**