Prescriber Criteria Form Stelara 2025 PA Fax 560-A v2 010125.docx Stelara (ustekinumab) Coverage Determination
This fax machine is located in a secure location as required by HIPAA regulations. Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673.** Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Stelara (ustekinumab).

Drug Name: Stelara (ustekinumab)

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Has the patient previously received the requested drug for any of the following conditions: A) plaque psoriasis, B) psoriatic arthritis, C) Crohn's disease, D) ulcerative colitis? [If yes, then no further questions.]	Yes ◯	No ◯
2	Does the patient have a diagnosis of moderate to severe plaque psoriasis? [If no, then skip to question 5.]	Yes ◯	No ◯
3	Does the patient meet any of the following criteria: A) at least 3 percent of the body surface area (BSA) was affected by plaque psoriasis at the time of diagnosis, B) crucial body areas (e.g., feet, hands, face, neck, groin, intertriginous areas) were affected by plaque psoriasis at the time of diagnosis? [If no, then no further questions.]	Yes ◯	No ◯
4	Does the patient meet any of the following criteria: A) patient has experienced an inadequate treatment response or intolerance to either phototherapy (e.g., ultraviolet B [UVB], psoralen plus ultraviolet A [PUVA]) or pharmacologic treatment with methotrexate, cyclosporine, or acitretin, B) pharmacologic treatment with methotrexate, cyclosporine, or acitretin is contraindicated, C) patient has severe psoriasis that warrants a biologic as first-line therapy (i.e. at least 10 percent of the body surface area [BSA] or crucial body areas [e.g., hands, feet, face, neck, scalp, genitals/groin, intertriginous areas] are affected)? [No further questions.]	Yes ◯	No ◯
5	Does the patient have a diagnosis of active psoriatic arthritis? [If yes, then no further questions.]	Yes ◯	No ◯

6	Does the patient have a diagnosis of moderately to severely active Crohn's disease? [If yes, then no further questions.]	Yes ◯	No ◯
7	Does the patient have a diagnosis of moderately to severely active ulcerative colitis?	Yes ◯	No ◯

Comments:	_____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.
Prescriber (or Authorized) Signature: _____ Date:_____