

Stelara (ustekinumab)

Prior Authorization Request (Physician to Complete)



An Independent Licensee of the Blue Cross and Blue Shield Association

Visit www.wellmark.com for the Wellmark Drug List for current medication tier levels and updated PA Forms

Facsimile Transmittal Sheet

Date: ____/____/____

To: Wellmark Pharmacy Services

From (Prescriber's Name): _____

Fax Number: (866) 884-4345

Prescriber's DEA Number: _____

Phone Number: (800) 600-8065

Prescriber's Phone Number: _____

Prescriber's Specialty: _____

Prescriber's Fax Number: _____

Prescriber's Office Address: _____
Street Suite # City State Zip

Patient Name: _____

Patient ID: _____ Patient DOB: ____/____/____

Please answer the following questions and fax this form back to (866) 884-4345. All fields are REQUIRED.

1. Please provide the diagnosis this therapy has been prescribed for: _____

ICD-9 Code: _____

If the treatment is for moderate to severe plaque psoriasis, does it affect at least 10% of the patient's body surface area (BSA)? Yes No

Does the psoriasis affect the hands, feet, face, scalp, or genitals? Yes No

2. Has the patient had a pre-treatment evaluation of tuberculosis? Yes No

3. Has the patient failed any of the following therapies (select all that apply)?

- Gengraf, Neoral, and/or Sandimmune (cyclosporine)
- Enbrel (etanercept)
- Glucocorticoids
- Humira (adalimumab)
- Imuran (azathioprine)
- Methotrexate
- Soriatane (acitretin)
- UVB/PUVA Phototherapy

Printed Name

Signature

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