



Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **Stelera (ustekinumab)**. Please complete all sections, incomplete forms will delay processing. Fax this form back to Kaiser Permanente within 24 hours fax: 1-866-331-2104. If you have any questions or concerns, please call 1-866-331-2103. **Requests will not be considered unless this form is complete.** The KP-MAS Formulary can be found at: [Pharmacy | Community Provider Portal | Kaiser Permanente](#)

1 – Patient Information

Patient Name: _____ Kaiser Medical ID#: _____ Date of Birth: _____

2 – Provider Information

Provider Name: _____ Specialty: _____ Provider NPI: _____

Provider Address: _____

Provider Phone #: _____ Provider Fax #: _____

Please check the boxes that apply:

- Initial Request Continuation of Therapy Request

3 – Pharmacy Information

Pharmacy Name: _____ Pharmacy NPI: _____

Pharmacy Phone # _____ Pharmacy Fax #: _____

4 – Drug Therapy Requested

Drug 1: Name/Strength/Formulation: _____

Sig: _____

Drug 2: Name/Strength/Formulation: _____

Sig: _____

5– Diagnosis/Clinical Criteria

1. Does the member have diagnosis of one of the following? **AND**
 - Adult Crohn’s disease (CD)
 - Psoriatic arthritis (PsA) (patients ≥6 years of age)
 - Adult Ulcerative Colitis (UC)
 - Plaque Psoriasis (PsO) moderate to severe (patients ≥6 years of age)
 - Other: _____
2. Was there therapeutic failure on oral methotrexate? **AND**
 - No Yes
3. Was there therapeutic failure to one of the preferred agents? (e.g. Enbrel, Humira)
 - No Yes
4. If the indication is for Plaque Psoriasis or Psoriatic Arthritis is the patient’s age ≥ 6 years?
 - No Yes

6 – Provider Sign-Off

Additional Information –

1. **Please submit chart notes/medical records for the patient that are applicable to this request.**
2. **If member has not tried preferred agent(s) please provide rationale/explanation and any additional supporting information that should be taken into consideration for the requested medication:**

I certify that the information provided is accurate. Supporting documentation is available for State audits.

Provider Signature:	Date:
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