Health Partners Plans

HEALTH PARTNERS MEDICARE
PRIOR AUTHORIZATION REQUEST FORM

Stelara - Medicare

Phone: 215-991-4300 **Fax back to: 866-371-3239**

Health Partners Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**	
Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Line of Business: ☐ Medicare	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

☐ REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that applying the 72 hour standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:
Strength:
Directions / SIG:

Please attach any pertinent medical history including labs and information for this member that may support approval.
Please answer the following questions and sign.

Q1. Is Stelara being prescribed by or in consultation with a dermatologist, rheumatologist, or gastroenterologist?

☐ Yes ☐ No

Q2. Has the patient been evaluated for tuberculosis (TB) infection and active infection?

☐ Yes ☐ No

Q3. Does the patient have a confirmed diagnosis of moderate to severe plaque psoriasis and is a candidate for phototherapy or systemic therapy?

☐ Yes ☐ No

Q4. Is the patient 12 to 17 years of age?

☐ Yes ☐ No

Q5. Is there documentation of an inadequate response, intolerance, or contraindication to Enbrel?

☐ Yes ☐ No

Q6. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q7. Is there documentation of an inadequate response, intolerance, or contraindication to one tumor necrosis factor antagonist (such as Enbrel or Humira)?

☐ Yes ☐ No

This telecopy transmission contains confidential information belonging to the sender that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reference to the contents of this document is strictly prohibited. If you have received this telecopy in error, please notify the sender immediately to arrange for the return of this document

Health Partners Plans

HEALTH PARTNERS MEDICARE
PRIOR AUTHORIZATION REQUEST FORM

Stelara - Medicare

Phone: 215-991-4300 **Fax back to: 866-371-3239**

Health Partners Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name: | **Prescriber Name:**

Q8. Does the patient have a confirmed diagnosis of active psoriatic arthritis?

☐ Yes ☐ No

Q9. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q10. Is there documentation of an inadequate response, intolerance, or contraindication to at least one disease modifying anti-rheumatic drug (DMARD) (such as methotrexate, hydroxychloroquine, sulfasalazine) AND one tumor necrosis factor antagonist (such as Enbrel or Humira)?

☐ Yes ☐ No

Q11. Does the patient have a confirmed diagnosis of moderately to severely active Crohn's disease?

☐ Yes ☐ No

Q12. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q13. Is there documentation of an inadequate response, intolerance, or contraindication to immunomodulators (such as methotrexate, azathioprine), corticosteroids, or one tumor necrosis factor antagonist (such as Humira)?

☐ Yes ☐ No

Q14. Will the medication be furnished by the prescriber/office, administered in the prescriber's office or ambulatory setting, be billed by the prescriber/office, and covered under Medicare Part B?

☐ Yes ☐ No

Q15. Does the prescriber want to have the medication provided by a pharmacy and covered under Medicare Part D?

☐ Yes ☐ No

Q16. Additional Information:

Q17. Duration:

☐ 12 months

Prescriber Signature

Date

2020 Medicare Prior Authorization Request

This telecopy transmission contains confidential information belonging to the sender that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reference to the contents of this document is strictly prohibited. If you have received this telecopy in error, please notify the sender immediately to arrange for the return of this document