USTEKINUMAB (Stelara®) injection

PRIOR REVIEW/CERTIFICATION FAXBACK FORM

INCOMPLETE FORMS MAY DELAY PROCESSING
ALL NC PROVIDERS MUST PROVIDE THEIR 5-DIGIT BCBSNC PROVIDER ID# BELOW

PRESCRIBER INFORMATION		PATIENT INFORMATION	
PHYSICIAN NAME	PROVIDER ID/TAX ID (if out of state must have tax ID)	PATIENT NAME	
CONTACT PERSON/PRACTICE NAME		PATIENT'S BCBSNC ID	
PRACTICE PHONE	PRACTICE FAX	PATIENT'S DATE OF BIRTH	
PRACTICE ADDRESS	CITY	STATE	ZIP

Please answer the following questions: **Dx Code_________**

1) Is this drug being prescribed for moderate to severe plaque psoriasis?.................................... ☐Yes ☐No

2) Has the patient already been treated with phototherapy (such as PUVA or broadband or narrowband UVB)?... ☐Yes ☐No

3) Is the patient a candidate for receiving phototherapy? .... ☐Yes ☐No
☐Phototherapy not available to the patient

4) Has the patient tried and failed systemic therapy (e.g., methotrexate, cyclosporine, acitretin [Soriatane®]), or has a contraindication to these therapies? .... ☐Yes ☐No

5) Will the patient be receiving more than one biologic agent at the same time? .... ☐Yes ☐No

6) Is the patient 18 years of age or older?... ☐Yes ☐No

__Note__: *If you are prescribing greater than **90mg every 12 weeks** for maintenance therapy of Stelara, please complete and sign **page 2.

Please certify the following by signing and dating below:

I certify that I have been authorized to request prior review and certification for the above requested service(s). I further certify that my patient's medical records accurately reflect the information provided. I understand that BCBSNC may request medical records for this patient at any time in order to verify this information. I further understand that if BCBSNC determines this information is not reflected in my patient's medical records, BCBSNC may request a refund of any payments made and/or pursue any other remedies available.

Prescriber's Signature (Required):____________________________________Date:_________________

For BCBSNC members, fax form to 1-800-795-9403

For NC State Health Plan members (Member ID starts with YPY), fax form to 1-866-225-5258

BlueCross BlueShield of North Carolina

COMPLETE PAGE 2 *ONLY* TO REQUEST QUANTITY LIMIT EXCEPTION FOR STELARA

PRESCRIBER INFORMATION		PATIENT INFORMATION
PHYSICIAN NAME	PROVIDER ID/TAX ID (if out of state must have tax ID)	PATIENT NAME
CONTACT PERSON/PRACTICE NAME		PATIENT'S BCBSNC ID
PRACTICE PHONE	PRACTICE FAX	PATIENT'S DATE OF BIRTH
PRACTICE ADDRESS	CITY	STATE ZIP

If you are requesting a quantity above the amount listed, check the appropriate box and provide the medical necessity of the increased dosage requested.

Please note: *This medication requires a* ***prior authorization*** *before a quantity limit override can be considered. Before submitting a request for a quantity level override, please ensure that a prior approval authorization has been submitted and/or approved (page 1). Otherwise, this request will deny.*

Dx Code:_____________

Requested drug dose:

☐ greater than **90mg every 12 weeks** for maintenance therapy of Stelara

Provide dosage requested and a description of medical necessity / rationale for this request:

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Please certify the following by signing and dating below:

I certify that I have been authorized to request prior review and certification for the above requested service(s). I further certify that my patient's medical records accurately reflect the information provided. I understand that BCBSNC may request medical records for this patient at any time in order to verify this information. I further understand that if BCBSNC determines this information is not reflected in my patient's medical records, BCBSNC may request a refund of any payments made and/or pursue any other remedies available.

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