Blue Cross Blue Shield Blue Care Network of Michigan

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Blue Cross Medicare Plus Blue℠ PPO and BCN Advantage℠ Medication Authorization Request Form Stelara® (ustekinumab) J3357/J3358

The most efficient way to request authorization is to use the NovoLogix® system. To access NovoLogix, visit bcbsm.com/providers and log in to Provider Secured Services. Click the link for Medical Prior Authorization. As an alternative, you can use this form to request authorization. Complete this form and fax to 1-866-392-6465. If you have any questions regarding this process, contact the Pharmacy Clinical Help Desk at 1-800-437-3803.

PATIENT INFORMATION	PHYSICIAN INFORMATION
Name	**Name**
ID Number	**Specialty**
Date of birth ☐Male ☐Female	**Address**
Diagnosis (include ICD-10)	**City /State/Zip**
Drug Name	**Phone:** ( ) - **Fax:** ( ) -
Dose and Quantity	**NPI**
Directions	**Contact Person**
Date of Services	**Contact Person's Phone / Ext.**

STEP 1: DISEASE STATE INFORMATION

1. Is this request for self or office-administration?
   ☐ Self-Administration ☐ Office Administration. Which route? ☐ Intravenous ☐ Subcutaneous

2. Initial or Continuation request? ☐ Initial ☐ Continuation. Please specify date of last injection _____

3. Please check the patient's diagnosis:
   ☐ Moderate to Severe Plaque Psoriasis ☐ Psoriatic Arthritis
   ☐ Moderate to Severe Crohn's disease ☐ Moderate to Severe Ulcerative Colitis
   ☐ Other_____

4. Which of the following therapies has the patient tried and failed?
   ☐ Phototherapy or Photochemotherapy ☐ Oral systemic agent for psoriasis (such as methotrexate, acitretin, cyclosporine)
   ☐ Nonbiologic DMARD for psoriatic arthritis (such as methotrexate, sulfasalazine, cyclosporine, leflunomide)
   ☐ Conventional therapy for Crohn's disease or Ulcerative Colitis (such as corticosteroids or immunomodulators such as azathioprine, methotrexate, 6-mercaptopurine)
   ☐ Infliximab biosimilars such as Inflectra®, Renflexis®, or Avsola™ ☐ Remicade®
   ☐ Other_____

5. **Continuation for Plaque Psoriasis**: How did the patient respond to therapy?
   ☐ Achieved PASI 75 response ☐ Greater than 50% reduction in body surface area covered by psoriasis compared to baseline
   ☐ Improvement in clinical symptoms ☐ Clinically stable ☐ Other _____

6. **Continuation for Crohn's disease or Ulcerative Colitis**: How did the patient respond to therapy?
   ☐ Achieved clinical response to symptoms ☐ Achieved remission ☐ Clinically stable
   ☐ Other_____

7. Please attach any chart notes or additional documentation and submit to plan. ***(Required)***

Coverage won't be provided if the prescribing physician's signature and date aren't reflected on this document.

☐ Request for expedited review: I certify that applying the standard review time frame may seriously jeopardize the life or health of the member or the member's ability to regain maximum function

Physician's Name **Physician's Signature** **Date**

Step 2: Checklist	☐ Form Completely Filled Out ☐ Attached Chart Notes	☐ Concurrent Medical Problems ☐ Prior Therapies
Step 3: Submit	**Fax the completed form to 1-866-392-6465**	