CVS CAREMARK

Fax Referral To: 800-323-2445

Phone: 866-278-6634

Stelara™ Enrollment Form

For Blue Cross Blue Shield of Rhode Island Members

Date: _____ **Needs by Date (Please Specify):** _____

Ship to: ☐ **Patient** ☐ **Office** ☐ **Other:** _____

PATIENT INFORMATION

*(Complete the following or **send patient demographic sheet**)*

Patient Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
Alternate Phone: _____
SS #: _____
Insurance ID: _____
Date of Birth: _____ Gender: _____

PRESCRIBER INFORMATION

Prescriber's Name: _____
State License #: _____ UPIN: _____
DEA #: _____ NPI #: _____
Group or Hospital: _____
Address: _____
City, State Zip: _____
Phone: _____ Fax: _____
Contact Person: _____
Contact Phone: _____

INSURANCE INFORMATION *(If available, please copy and attach the front and back of insurance and prescription drug card)*

Primary Insurance: Subscriber: _____ Subscriber ID#: _____ Name of Insurer: **Blue Cross Blue Shield of RI**

Secondary Insurance: Subscriber: _____ Subscriber ID#: _____ Name of Insurer: _____

STATEMENT OF MEDICAL NECESSITY for BCBS of Rhode Island Members

Diagnosis (ICD-9 Code): ☐ _____ • Date of Diagnosis: _____

Approval Criteria: CHECK ALL BOXES THAT APPLY

Please note: Any areas that are not filled out will be considered not applicable to your patient and MAY AFFECT THE OUTCOME OF THIS REQUEST

- Is the patient currently receiving Stelara? ☐ Yes ☐ No If yes, please answer the last two questions.
- How old is the patient? _____ years
- Prior to initiating therapy, was the patient tested for tuberculosis (TB)? ☐ Yes ☐ No
- Was latent TB infection ruled out? ☐ Yes ☐ No
- Is the patient receiving treatment for latent TB infection or has treatment for latent TB been completed? ☐ Yes ☐ No
- Does patient have active TB or any other serious active infection? ☐ Yes ☐ No
- Will Stelara be used in combination with any other biologic medication(s)? (e.g. Humira, Remicade) ☐ Yes ☐ No
- What percent of Body Surface Area (BSA) is affected? _____ %
- What is the affected area of the body? ☐ Hands ☐ Feet ☐ Face ☐ Neck ☐ Groin ☐ Other _____
- Does the psoriasis cause disruption of daily activities? ☐ Yes ☐ No
- Has the patient had an insufficient response to systemic therapies for plaque psoriasis, or is such therapy contraindicated or not tolerated? ☐ Yes ☐ No
- Was the patient adherent to the prescribed treatments? ☐ Yes ☐ No
- Has dose/route been optimized without adequate response? ☐ Yes ☐ No
- Is there a clinical reason to avoid phototherapy or systemic therapies as initial treatment? ☐ Yes ☐ No
- If yes, please document the reason. _____

Only answer below questions if patient is currently receiving Stelara.

- What is the patient's weight? _____ kg
- Has the patient had an inadequate response to 45 mg/dose? ☐ Yes ☐ No

PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐ Stelara™	☐ 45mg/0.5ml ☐ 90mg/mL	☐ Inject _____mg SC initially and 4 weeks later, followed by 45mg every 12 weeks ☐ Inject _____mg SC initially and 4 weeks later, followed by 90mg every 12 weeks.		

_____ PRODUCT SUBSTITUTION PERMITTED (Date)

_____ DISPENSE AS WRITTEN (Date)