



# scan<sup>TM</sup>

Stelara

**Express Scripts**  
**Prior Authorization**  
**Phone 1-844-424-8886**  
**Fax 1-877-251-5896**

To start your Part D Coverage Determination request, you (or your representative or your doctor or other prescriber) should contact Express Scripts, Inc (ESI):

- You may Call ESI at 1-844-424-8886, 24 hours a day, 7 days a week,  
TTY users: 1-800-716-3231
- You may Fax your request to: 1-877-251-5896 (Attention: Medicare Reviews)
- You may also send your request via email to: [medicarepartdparequests@express-scripts.com](mailto:medicarepartdparequests@express-scripts.com)

Member's Last Name:	Member's First Name:
SCAN ID number:	Date of Birth:
Prescriber's Name:	Contact Person:
Office phone:	Office Fax:
Medication:	Diagnosis:

## SECTION A

Please answer the following questions

1. ☐ Yes ☐ No Is the indication or diagnosis for the treatment of moderate to severe Crohn's disease? *(if YES, skip to question 9).*
2. ☐ Yes ☐ No Is the indication or diagnosis for the treatment of plaque psoriasis?
3. ☐ Yes ☐ No Has the member previously used at least one systemic therapy (e.g., methotrexate, cyclosporine, acitretin, etc.) prior to the initiation of Stelara if the member is a candidate for systemic therapy? *(if YES, skip to question 9).*
4. ☐ Yes ☐ No Has the member previously used a biologic or is currently using ustekinumab (Stelara)? *(if YES, skip to question 9).*
5. ☐ Yes ☐ No Is the indication or diagnosis for the treatment of moderately to severely active ulcerative colitis?
6. ☐ Yes ☐ No Has the member previously used at least one conventional therapy (e.g., a corticosteroid, azathioprine, or 6-mercaptopurine, etc.) prior to the initiation of Stelara? *(if YES, skip to question 9).*

7. ☐ Yes ☐ No Has the member previously used a biologic or is currently using ustekinumab (Stelara)? *(if YES, skip to question 9).*
8. ☐ Yes ☐ No Is the indication or diagnosis for the treatment of active psoriatic arthritis?
9. ☐ Yes ☐ No Will the requested medication be concomitantly used with biologic DMARDs (e.g., TNF antagonists)?
- 10 ☐ Yes ☐ No Is the prescription written or recommended by a rheumatologist, dermatologist, or gastroenterologist?

***Please document the symptoms and/or any other information important to this review:***

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**SECTION B** Physician Signature

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PHYSICIAN SIGNATURE

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DATE

**FAX COMPLETED FORM TO: 1-877-251-5896**

Our response time for prescription drug coverage standard requests is 72 hours. If you or your prescriber believe that waiting 72 hours for a standard decision could seriously harm your life, health, or ability to regain maximum function, you can ask for an expedited (fast) decision. If your prescriber indicates that waiting 72 hours could seriously harm your health, we will automatically give you a decision within 24 hours. If you do not obtain your prescriber's support for an expedited request, we will decide if your case requires a fast decision. You cannot request an expedited coverage determination if you are asking us to pay you back for a drug you already received. View our formulary and Prior Authorization criteria online at <http://www.scanhealthplan.com>