

CRITERIA FOR PRIOR AUTHORIZATION

Stelara® (ustekinumab)

PROVIDER GROUP Pharmacy
Professional

MANUAL GUIDELINES The following drug requires prior authorization:
Ustekinumab (Stelara®)

CRITERIA FOR PLAQUE PSORIASIS (must meet all of the following):

- Patient must have a diagnosis of plaque psoriasis
- Must be prescribed by a rheumatologist or dermatologist
- Evaluation for latent tuberculosis (TB) with TB skin test prior to initial prior authorization approval
- Patient must be 18 years of age or older
- Patient has not taken another biologic agent (see attached table) in the past 30 days
- Patient must be a candidate for systemic therapy or phototherapy
- Dose must not exceed 45 mg per injection. If prescriber is seeking 90 mg per dose, documentation of the patient's weight is required and/or that 45 mg has not been efficacious

CRITERIA FOR PSORIATIC ARTHRITIS (PSA) (must meet all of the following):

- Patient must have a diagnosis of psoriatic arthritis
- Must be prescribed by a rheumatologist or dermatologist
- Evaluation for latent TB with TB skin test prior to initial prior authorization approval
- Patient must be 18 years of age or older
- Patient has not taken another biologic agent (see attached table) in the past 30 days
- Dose must not exceed 45 mg per injection. If prescriber is seeking 90 mg per dose, documentation of patient's weight and coexisting moderate to severe plaque psoriasis is submitted

CRITERIA FOR CROHN'S DISEASE (CD) (must meet all of the following):

- Patient must have a diagnosis of Crohn's disease
- Patient must have one of the following:
 - failed or were intolerant to treatment with immunomodulators or corticosteroids, but never failed a tumor necrosis factor (TNF) blocker
 - failed or were intolerant to treatment with one or more TNF blockers
- Must be prescribed by a gastroenterologist
- Evaluation for latent TB with TB skin test prior to initial prior authorization approval
- Patient must be 18 years of age or older
- Patient has not taken another biologic agent (see attached table) in the past 30 days

LENGTH OF APPROVAL 12 months

 DRUG UTILIZATION REVIEW COMMITTEE CHAIR

 PHARMACY PROGRAM MANAGER
 DIVISION OF HEALTH CARE FINANCE
 KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT

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Biologic Agents	
Generic Name	Brand Name
Abatacept	Orencia®
Etanercept	Enbrel®, Erelzi®
Alefacept	Amevive®
Anakinra	Kineret®
Certolizumab	Cimzia®
Golimumab	Simponi®
Infliximab	Remicade®, Inflectra®
Natalizumab	Tysabri®
Rituximab	Rituxan®
Tocilizumab	Actemra®
Adalimumab	Humira®, Amjevita®
Secukinumab	Cosentyx®
Vedolizumab	Entyvio®
Canakinumab	Illaris®