



Kansas Medical Assistance Program
P O Box 3571
Topeka, KS 66601-3571
Provider 1-800-933-6593
Beneficiary 1-800-766-9012

Stelara® (ustekinumab) Prior Authorization Request Form

Beneficiary Information

Name: _____
Medicaid ID #: _____ Date of Birth: _____

Billing Provider Information (Pharmacy, Physician, or Facility)

Name: _____ Medicaid ID #: _____
NPI #: _____ Phone #: _____ Fax #: _____
Requested Drug: _____ NDC: _____
Requested Procedure Code (if applicable) _____ Total # of Units Requested (per 6 months) _____

Prescriber Information

Name: _____ Medicaid ID # _____
NPI #: _____ Phone #: _____ Fax #: _____

Requested Information

1. Please indicate the diagnosis for which Stelara is being prescribed (no diagnosis codes):

2. What specialty of the prescriber?
 Rheumatologist Dermatologist Other (please specify): _____
3. Lab results:
TB Skin Test Date: _____ TB Skin Test Result: Positive Negative
4. Has the patient taken any biologics in the past 30 days? Yes No
If 'Yes', which agent(s): _____
5. If Stelara is being prescribed for Plaque Psoriasis, is the patient a candidate for systemic or phototherapy?
 Yes No

Prescriber's Signature: _____ Date: _____

**The completed form should be faxed to the HP Prior Authorization Unit at 1-800-913-2229.
This form will be returned unprocessed if it is not completed in its entirety.**