



PRIOR AUTHORIZATION PROGRAM FORM

Stelara® (Ustekinumab)

Instructions:

1. Section 1 to be completed by Plan Member/ Patient
2. Section 2 to be completed by Physician/ Pharmacist (expenses incurred by the completion of this form is at plan member's expense)
3. Section 3 to be completed by Pharmacist.

Please fax completed form to NexgenRx Formulary Management to 1-877-639-4369 or mail to 145 The West Mall P.O. Box 110 U, Toronto, Ontario, M8Z-5M4

Section 1: To be completed by Patient

Member's Name: (Last, First)	Card ID Number:																			
Patient's Name: (Last, First)	Patient's Date of Birth (dd/mm/yy)		Relationship to Member (please circle)			PATIENT CODE														
			Employee			Spouse			Dependent											

Results of this request to be communicated to:

<input type="checkbox"/> Pharmacy	<input type="checkbox"/> Patient / Legal Guardian Named Below	<input type="checkbox"/> email:
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I authorize NexgenRx Inc. (a) to use the personal information disclosed on this form, and any other personal information known to NexgenRx Inc. regarding the above-named patient, for the purpose of assessing this prior authorization request and any related claim and administering the benefit plan under which any such claim is made, and (b) to contact, and to obtain any such personal information from and to disclose any such personal information to, any physician, pharmacist or other health care professional having knowledge of such patient's health relevant to this request and any related claim.

Patient / Legal Guardian Name: _____ Telephone Number: _____

Signature of Patient/ Legal Guardian: _____ Date (dd/mm/yy): _____

Section 2: To be completed by Physician/ Pharmacist

Drug Name & Strength:	DIN:	Dosage Instructions:

Eligibility for drug coverage is dependent upon the patient meeting at least one of the qualifying criteria listed below. If the patient has another drug plan, prior authorization may cover some or all of the excess not paid by the primary plan.

Please indicate if the patient meets at least one of the following qualifying criteria for drug coverage:

- To treat chronic moderate to severe plaque psoriasis in adults who are candidates for phototherapy or systemic therapy.
- Stelara is indicated for the treatment of chronic moderate to severe plaque psoriasis in adolescent patients from 12 to 17 years of age, who are inadequately controlled by, or are intolerant to, other systemic therapies or phototherapies.
- Stelara is indicated for the treatment of adult patients with active psoriatic arthritis. Stelara can be used alone or in combination with methotrexate (MTX).

Physician / Pharmacist Name: (Last, First)	License Number:
Address: (Street, City, Province, Postal Code)	Telephone Number : () - Fax Number: () -
Signature of Physician / Pharmacist:	Date (dd/mm/yy)

Section 3: To be completed by Pharmacist

Pharmacy Name:	Provider Number:
Pharmacy Address: (Street, City, Province, Postal Code)	Telephone Number : () - Fax Number: () -
Signature of Pharmacist: _____	
Pharmacist's Name: (Print Last, First) _____	

Internal Office Use Only:

Date Received:		Date Approved: