Sherry l
Manzo

ORANGE REGIONAL MEDICAL CENTER

CHEMOTHERAPY ORDERS

Patient Label

TO BE COMPLETED BY PHYSICIAN: Patient Name: Sherry l manzo DOB: 5-20-49

Date Written: 10-3-17 | Date of Administration:

Diagnosis: crcns | TNM Stage:

Protocol / Regimen – St-clara | Cycle of Day

Allergies: ☒ NKDA

APPROVED 10-9-14

Venous Access: ○ Peripheral ○ Central

Height	Weight	Body Surface Area (m^2)	Emetic Level
5 ft 1 in	kg ○ Actual ○ Ideal ○ Adjusted ◉ Dosing		☐ Minimal ☐ Moderate ☐ High

Lab Orders: ☐ CBC/DIFF ☐ BMP ☐ Magnesium ☐ UA

Hold Parameters:

ANC less than: WBC less than: PLT less than: Hgb/Hct less than: SCr greater than:

Non-chemotherapy orders:	RPh Initials / Nurse Initials	
☐ IV Fluids: NS @ KVO (20 mL/hr)		

Solution, volume and infusion rate are per manufacturer/hospital guidelines unless otherwise specified. Chemotherapeutic agents will be rounded down to nearest vial size if within 5% of calculated dose. Biological agents will be rounded down to the nearest vial size if within 10% of calculated dose. Please administer chemotherapy in sequence listed below.

Chemotherapy	Dose per Unit (m^2, kg, AUC)	Dose Reduction* (mg/m^2, mg/kg, AUC)	Calculated Dose	Dose Dispensed (Rounding to be completed by RPh)	Route	Infusion Rate	RPh / Nurse Initials	
St clara	520mg			520mg	IV			

*If using a dose reduction, please provide rationale:

MD Name (Print) [illegible] MD Signature _____ Date/Time 10-3-17

RN Name (Print) _____ RN Signature _____ Date/Time _____

RPh Name (Print) _____ RPh Signature _____ Date/Time _____

OPTUMRx®

ALAN GOLDFISCHER
30 HATFIELD LANE
STE 107
GOSHEN, NY 10924

Hours of Operation:
5 a.m. - 10 p.m. PT, Monday-Friday
6 a.m. - 3 p.m. PT, Saturday
Date: 09/21/2017

Address:
3515 Harbor Blvd
M/S CA-106-0286
Costa Mesa, CA 92626

To:	ALAN GOLDFISCHER	From:	OptumRx
Phone:	(845)615-4000	Phone:	1-800-711-4555
Fax:	8456154002	Fax:	1-800-527-0531
Reference #:	PA-37963160	Specialty Fax:	1-800-853-3844
RE:	Prior Authorization Request		

Patient Name: SHERRYL MANZO
Patient DOB: 05/20/1949
Patient ID#: 0102883881
Decision Made: Approve
Medication Name: STELARA
GPI/NDC: 52504070002020

Decision Notes:

STELARA INJ 5MG/ML, use as directed, is approved for non-formulary exception through 12/31/2017 under your Medicare Part D benefit. Reviewed by: qreese

*Specialty Pharmacy is available by phone 5 a.m. – 7 p.m. PT, Monday-Friday

Horizon Family Medical Group
30 Hatfield Lane, Suite 107
Goshen, NY 10924
Ph: 845-703-8806 Fax: 845-703-9058
Ph: 845-615-4000 Fax: 845-615-4002

FAX COVER SHEET

Date: 10-3-17

To: ORMC

Fax: 333 1157

Re: Sherri Manzo

Dob: 5-20-49

From: Dr Goldfischer

Pages: 3

Comments:
New Start Steara-

CANCER CARE CENTER

707 East Main Street
Middletown NY 10940

Encounter Date: ~~5/22/2017~~ 7/11/17
Hospital Account: ~~5000823890~~ 8260252
MRN: 10719
Site: CANCER CARE
Contact Serial #: 8311561

9/11/17
898794

ENCOUNTER

Department:	CC INFUSION CENTER	Appt Time:	11:30 AM EDT
Appointment Provider:	CC INF CHAIR 11	Visit Type:	INF ENTYVIO 2 HRS
Attending Provider:		Referring Physician:	Goldfischer, Alan B, MD
Diagnosis:	K50.80		

PATIENT

Name:	MANZO,SHERRYL B	Age:	68 y.o. DOB: 5/20/1949
Address:	80 SUSAN LANE	Sex:	Female
City:	CIRCLEVILLE, NY 10919	Language:	English [22]
PCP:	Hirsch, Andrew D, DO	Primary Phone:	561-964-2132

EMERGENCY CONTACT

Contact Name	Legal Guardian?	Relationship to Patient	Home Phone	Work
1. Manzo,Richard		Spouse	(561)964-2132	
2. *No Contact Specified*				

GUARANTOR

Guarantor:	MANZO,SHERRYL B	DOB:	5/20/1949
Address:	80 SUSAN LANE	Sex:	Female
	CIRCLEVILLE, NY 10919		
Relation to Patient:	Self	Home Phone:	561-964-2132
Guarantor ID:	164581	Work Phone:	

GUARANTOR EMPLOYER

Employer:		Status:	RETIRED

COVERAGE

PRIMARY INSURANCE

Payor:	MEDICARE	Plan:	MEDICARE PART A & B
Group Number:		Insurance Type:	INDEMNITY
Subscriber Name:	MANZO,SHERRYL B	Subscriber DOB:	05/20/1949
Subscriber ID:	064407977A	Verification Status:	
Pat. Rel. to Subscriber:	Self		

A B 6/1/10

SECONDARY INSURANCE

Payor:	AARP	Plan:	AARP COMM
Group Number:		Insurance Type:	INDEMNITY
Subscriber Name:	MANZO,SHERRYL B	Subscriber DOB:	5/20/1949
Subscriber ID:	02709532411	Verification Status:	
Pat. Rel. to Subscriber:	SELF		

1/1/17 C
Y,Y

353059

~~Entyvio - J3380~~
Stelara - ok - J3357 - NO LCD

Shirley Manzo

ORANGE REGIONAL MEDICAL CENTER

CHEMOTHERAPY ORDERS

Patient Label

TO BE COMPLETED BY PHYSICIAN: Patient Name: Shirley Manzo DOB: 5-20-xx

Date Written: 9-7-17 Date of Administration:

Diagnosis: Crohns TNM Stage:

Allergies: ☒ NKDA

Protocol / Regimen – Entyvio Cycle of Day

PPD 9-10-17

Venous Access: ○ Peripheral ○ Central

Height	Weight	Body Surface Area (m^2)	Emetic Level
5 ft 1 in	kg ● Actual ○ Ideal ○ Adjusted ○ Dosing		☐ Minimal ☐ Moderate ☐ High

Lab Orders: ☐ CBC/DIFF ☐ BMP ☐ Magnesium ☐ UA

Hold Parameters:

ANC less than: WBC less than: PLT less than: Hgb/Hct less than: SCr greater than:

Non-chemotherapy orders:	RPh Initials / Nurse Initials	
☒ IV Fluids: NS @ KVO (20 mL/hr)		
Entyvio 300mg in 250cc NS over 30min		

Solution, volume and infusion rate are per manufacturer/hospital guidelines unless otherwise specified. Chemotherapeutic agents will be rounded down to nearest vial size if within 5% of calculated dose. Biological agents will be rounded down to the nearest vial size if within 10% of calculated dose. Please administer chemotherapy in sequence listed below.

Chemotherapy	Dose per Unit (m^2, kg, AUC)	Dose Reduction* (mg/m^2, mg/kg, AUC)	Calculated Dose	Dose Dispensed (Rounding to be completed by RPh)	Route	Infusion Rate	RPh / Nurse Initials	

*If using a dose reduction, please provide rationale:

MD Name (Print) [illegible] MD Signature _____ Date/Time 9-7-17

RN Name (Print) _____ RN Signature _____ Date/Time _____

RPh Name (Print) _____ RPh Signature _____ Date/Time _____

Sherry Manzo

ORANGE REGIONAL MEDICAL CENTER

CHEMOTHERAPY ORDERS

Patient Label

TO BE COMPLETED BY PHYSICIAN: Patient Name: Sherry Manzo DOB: 5-20-49

Date Written: 7-12-17	**Date of Administration:**
Diagnosis: CRCNS	**TNM Stage:**
Protocol / Regimen – Emtuvio	**Cycle** of **Day**

Allergies: ☒ NKDA

PPD ⊖

10-9-16

Venous Access: ○ Peripheral ○ Central

Height	Weight	Body Surface Area (m^2)	Emetic Level
5 ft 1 in	kg ○ Actual ○ Ideal ○ Adjusted ◉ Dosing		☐ Minimal ☐ Moderate ☐ High

Lab Orders: ☐ CBC/DIFF ☐ BMP ☐ Magnesium ☐ UA

Hold Parameters:

ANC less than: **WBC less than:** **PLT less than:** **Hgb/Hct less than:** **SCr greater than:**

Non-chemotherapy orders:	RPh Initials / Nurse Initials	
☒ IV Fluids: NS @ KVO (20 mL/hr)		
Emtuvio 30mg in 250cc NS over 30min		

Solution, volume and infusion rate are per manufacturer/hospital guidelines unless otherwise specified. Chemotherapeutic agents will be rounded down to nearest vial size if within 5% of calculated dose. Biological agents will be rounded down to the nearest vial size if within 10% of calculated dose. Please administer chemotherapy in sequence listed below.

Chemotherapy	Dose per Unit (m^2, kg, AUC)	Dose Reduction* (mg/m^2, mg/kg, AUC)	Calculated Dose	Dose Dispensed *(Rounding to be completed by RPh)*	Route	Infusion Rate	RPh / Nurse Initials	

*If using a dose reduction, please provide rationale:

MD Name (Print) [illegible] MD Signature [signature] Date/Time 7-12-17

RN Name (Print) _____ RN Signature _____ Date/Time _____

RPh Name (Print) _____ RPh Signature _____ Date/Time _____

janssen CarePath

Stelara® (ustekinumab)

P.O. Box 218
Charlotte, NC 15146-2230
Phone 877-CarePath (877-227-3728)
Fax 866-769-3903

FAX COVER PAGE

To: ORMC (845)333-1157	Date/Time: 08/30/2017 02:40 PM
From: Bianca Comesana	Pages: 8
Subject: Sherryl Manzo	AA00UCLA

INFUSION BENEFITS (BNB):

Prior authorization is not required.

INJECTION MAINTENANCE BENEFITS (Pharmacy):

Prior authorization is required and not on file. Provider needs to complete the attached form and fax to 800-527-0531. Step Therapy is required; patient needs to have tried and failed 1 preferred biologic. Turnaround time is 24-72 Hours. Follow up calls can be made to Optum RX at 800-711-4555.

Once the prior authorization is on file, the prescription will be triaged to the preferred specialty pharmacy Briova at phone 800-850-9122 and fax 800-218-3221 billing the primary pharmacy benefits.

If you have any questions regarding the verification of benefits, please contact Bianca at 1-877-227-3728 ext: 201-6160.

Based on attached verification of patient benefits, assistance for your patient with out-of-pocket medication costs may be available:

Janssen CarePath can help direct you or your patient to independent foundations that may be able to help if your patient has government-funded insurance or has exhausted their commercial or private health insurance benefit and needs help with STELARA® medication cost.

Potential financial assistance programs are also available at JanssenPrescriptionAssistance.com/Stelara. You will find program information and eligibility requirements for patient assistance programs, including independent foundations that may have funding to help your patient with their medication costs for STELARA®.

If you do not wish to receive any future faxes from the Janssen CarePath, call 877-CarePath (877-227-3728), Monday through Friday, 8:00 AM to 8:00 PM ET or by fax at 866-769-3903. Your request will not be honored if (i) it is not made to the phone or fax number listed; (ii) it fails to identify the telephone number(s) at which you no longer wish to receive faxes; or (iii) subsequent to your request, you provide express invitation or permission to the sender, in writing or otherwise, to send such advertisements to you. The sender's failure to comply with an opt-out request within 30 days is unlawful.

Before prescribing STELARA®, please see full Prescribing Information and Medication Guide, available at StelaraHCP.com. Provide the Medication Guide to your patients and encourage discussion.

08/30/2017

Alan Goldfischer, MD
Kayla Unknown
Horizon Family Medical Group
30 Hatfield Ln Ste 107
Goshen, NY 10924

Dear Dr. Goldfischer,

As a service to you through Janssen CarePath, we have researched your patient's insurance benefits for therapy with STELARA® (ustekinumab). Based on our research for Sherryl Manzo, we have included a verification of those benefits that provide coverage for STELARA®.

As allowed by the current Patient Authorization or Business Associate Agreement on file, Janssen CarePath will also contact the patient to explain the insurance benefits included in this fax. Accordingly, it is recommended that the patient be alerted by your office to this call. If you have signed the Limitation of Services agreement, Janssen CarePath will only contact the patient if the patient requests services directly.

Case Coordinators are available through Janssen CarePath to:

- Assist with the Prior Authorization and appeals process
- Claim submission information, and billing and coding
- Explain Medical and Pharmacy Benefits to you and your patient
- Identify alternative funding sources for patient out-of-pocket costs

If you have any questions about this letter or STELARA®, please call Janssen CarePath at 877-CarePath (877-227-3728), Monday through Friday, between 8:00 AM and 8:00 PM, ET.

Sincerely,

Bianca Comesana
Janssen CarePath Care Coordinator

Before prescribing STELARA®, please see full Prescribing Information and Medication Guide available at StelaraHCP.com. Provide the Medication Guide to your patients and encourage discussion.

Patient insurance benefit investigation is provided as a service by The Lash Group, Inc., under contract for Janssen Biotech, Inc. In this regard, The Lash Group, Inc., assists healthcare professionals in the determination of whether treatment could be covered by the applicable third-party payer based on coverage guidelines provided by the payer and patient information provided by the healthcare provider under appropriate authorization following the provider's exclusive determination of medical necessity. This reimbursement support service has no independent value to providers apart from the product and is included within the cost of the product.

Importantly, insurance verification is the ultimate responsibility of the provider. Third-party reimbursement is affected by many factors. This document is presented for informational purposes only and is not intended to provide reimbursement or legal advice and does not promise or guarantee coverage, levels of reimbursement, payment or charge. Similarly, all CPT® and HCPCS codes are supplied for informational purposes only and represent no promise or guarantee that these codes will be appropriate or that reimbursement will be made. It is not intended to increase or maximize reimbursement by any payer. Laws, regulations and policies concerning reimbursement are complex and are updated frequently. While we have made an effort to be current as of the issue date of this document, the information may not be as current or comprehensive when you view it. We strongly recommend you consult with your counsel, payer organization, or reimbursement specialist for any reimbursement or billing questions. While The Lash Group, Inc., tries to provide correct information, they and Janssen Biotech, Inc., make no representations or warranties, expressed or implied, as to the accuracy of the information. In no event shall The Lash Group, Inc., or Janssen Biotech, Inc., or its employees or agents be liable for any damages resulting from or relating to the services. All providers and other users of this information agree that they accept responsibility for the use of this service.

Janssen CarePath

Primary Insurance Verification of Benefits

Stelara® (ustekinumab)

Patient Information	
Patient Name: Sherryl Manzo	**Date of Birth:** 05/20/1949
Payer Name: Medicare	**Employer Name:**
Plan Name: Medicare AB	**Plan Type:** Medicare
Policy Number: 064407977A	**Group Number:**
Policy Level: Primary	**Policy Effective Date:** 01/01/2017
Policy End Date: 12/31/2017	**Policy Renewal Date:** 01/01/2018
Payer Contact: Online	**Payer Phone:** (800)633-4227
Verified for Primary Diagnosis: K5090	**Self-Funded:** No
Site of Care: Hospital Outpatient, Prescribing MD's Office, Patient's Home	**Dr Goldfischer is In Network with this plan.**
Date Benefits Verified: 08/30/2017 **by:** Bianca Comesana	

Affordability Support

For patients using commercial or private insurance

Janssen Link

Providing STELARA® at no cost to eligible patients if commercial insurance delays (more than 5 days) or denies treatment

This program is not available to individuals who use any state or federal government-subsidized healthcare program to cover a portion of medication costs, such as Medicare, Medicaid, TRICARE, Department of Defense, or Veterans Administration or any other federal or state healthcare plan, including pharmaceutical assistance programs.

For patients using commercial or private insurance

Janssen CarePath SAVINGS PROGRAM

Eligible patients pay just $5 per dose*

*$20,000 maximum program benefit per calendar year. For medication cost only. Not valid for patients using Medicare or Medicaid. Eligibility requirements apply.

For patients using government insurance or patients without insurance coverage

Foundation support may be available through:

- The Assistance Fund at 855-845-3663
- Patient Access Network Foundation at 866-316-7263
- Patient Advocate Foundation at 800-532-5274

For patients with no health insurance or no coverage

- Visit JanssenPrescriptionAssistance.com/Stelara for a comprehensive list of affordability programs that may be available.

SUMMARY OF COVERAGE

(See following pages for additional details)

	Medical Buy and Bill Benefits	Medical Assignment of Benefits	Pharmacy Benefit	Additional Instructions
IV Induction	Yes			Yes
Sub-Q Maintenance Therapy		No	Yes	Yes

Patient ID: AA00UCLA and **Case ID:** 180829507

Before prescribing STELARA®, please see full Prescribing Information and Medication Guide, available at JanssenCarePath.com.

If you have any questions about this Verification of Benefits, please contact Janssen CarePath at 877-CarePath (877-227-3728), Monday–Friday, 8:00 AM – 8:00 PM ET

Patient insurance benefit investigation is provided as a service by The Lash Group, Inc., under contract for Janssen Biotech, Inc. In this regard, The Lash Group, Inc., assists healthcare professionals in the determination of whether treatment could be covered by the applicable third-party payer based on coverage guidelines provided by the payer and patient information provided by the healthcare provider under appropriate authorization following the provider's exclusive determination of medical necessity. This reimbursement support service has no independent value to providers apart from the product and is included within the cost of the product.

Importantly, insurance verification is the ultimate responsibility of the provider. Third-party reimbursement is affected by many factors. This document is presented for informational purposes only and is not intended to provide reimbursement or legal advice and does not promise or guarantee coverage, levels of reimbursement, payment, or charge. Similarly, all CPT® and HCPCS codes are supplied for informational purposes only and represent no promise or guarantee that these codes will be appropriate or that reimbursement will be made. It is not intended to increase or maximize reimbursement by any payer. Laws, regulations, and policies concerning reimbursement are complex and are updated frequently. While we have made an effort to be current as of the issue date of this document, the information may not be as current or comprehensive when you view it. We strongly recommend you consult with your counsel, payer organization, or reimbursement specialist for any reimbursement or billing questions. While The Lash Group, Inc., tries to provide correct information, they and Janssen Biotech, Inc., make no representations or warranties, expressed or implied, as to the accuracy of the information. In no event shall The Lash Group, Inc., or Janssen Biotech, Inc., or its employees or agents be liable for any damages resulting from or relating to the services. All providers and other users of this information agree that they accept responsibility for the use of this service.

janssen CarePath

Primary Insurance Verification of Benefits
IV Induction Therapy Details

Stelara® (ustekinumab)

Patient Information	
Patient Name: Sherryl Manzo	**Date of Birth:** 05/20/1949

Medical Buy and Bill Benefits		Medical Assignment of Benefits	
Major Medical Physician Purchase (Buy & Bill) Coverage for STELARA® Available: Yes		**Major Medical Assignment of Benefits (AOB) Coverage for STELARA® Available:**	
Prior Authorization Required for STELARA®: No		**Prior Authorization Required for STELARA®:**	
Prior Authorization Process for STELARA®:		**Prior Authorization Process for STELARA®:**	
Prior Authorization Required for Infusion Services: No		**Prior Authorization Required for Infusion Services:**	
Prior Authorization Process for Infusion Services:		**Prior Authorization Process for Infusion Services:**	
Payer Provided Reimbursement Codes*: IV: Q9989 per 520mg Vial at week zero. 96413/96365 are valid & billable admin codes. Actual reimbursement is based on payer contracts.		**Payer Provided Reimbursement Codes*:**	
Claims Address for Physician Claims: National Government Services, Inc. P.O. Box 6178 Indianapolis, IN 46206-6178		**Claims Address for Physician Claims:**	
Additional Instructions: The patient is responsible for the 20% coinsurance.		**Additional Instructions:**	
Deductible (Individual): $183.00	**Met:** $183.00	**Deductible (Individual):**	**Met:**
Deductible (Family):	**Met:**	**Deductible (Family):**	**Met:**
Out-of-Pocket Maximum:	**Met:**	**Out-of-Pocket Maximum:**	**Met:**
Lifetime Maximum: Unlimited	**Met:**	**Lifetime Maximum:**	**Met:**
Benefit Cap:	**Met:**	**Benefit Cap:**	**Met:**
Co-pay for Office Visit: $0.00		**Co-pay for Office Visit:**	
Co-pay for STELARA®: 20.00%		**Co-pay for STELARA®:**	

Pharmacy Benefits			
Pharmacy Benefits Coverage for STELARA® Available:			
Prior Authorization Required for STELARA®:			
Prior Authorization Process for STELARA®:			
Prior Authorization Required for Infusion Services:			
Prior Authorization Process for Infusion Services:			
Payer Provided Reimbursement Codes*:			
Additional Instructions:			
Deductible (Individual):	**Met:**	**Benefit Cap:**	**Met:**
Deductible (Family):	**Met:**	**Co-pay for Office Visit:**	
Deductible (Pharmacy):	**Met:**	**Co-pay for Mail Order:**	
Out-of-Pocket Maximum:	**Met:**	**Co-pay for Retail:**	
Lifetime Maximum:	**Met:**		

Patient ID: AA00UCLA **and Case ID:** 180829507

*These codes have been provided by the payer without edit and are not a representation of the condition or diagnosis of the patient. It is the provider's responsibility to determine and represent on any claim for reimbursement the patient's accurate condition or diagnosis.

Before prescribing STELARA®, please see full Prescribing Information and Medication Guide, available at JanssenCarePath.com.

janssen CarePath

Primary Insurance Verification of Benefits
Sub-Q Maintenance Therapy Details

Stelara® (ustekinumab)

Patient Information

Patient Name: Sherryl Manzo **Date of Birth:** 05/20/1949

Pharmacy Benefits		Medical Assignment of Benefits	
Pharmacy Benefits Coverage for STELARA® Available: Yes		**Major Medical Assignment of Benefits (AOB) Coverage for STELARA® Available:** No	
Prior Authorization Required for STELARA®: Yes		**Prior Authorization Required for STELARA®:**	
Prior Authorization Process for STELARA®: Prior authorization is required and not on file. Provider needs to complete the attached form and fax to 800-527-0531. Step Therapy is required; patient needs to have tried and failed 1 preferred biologic. Turnaround time is 24-72 Hours. Follow up calls can be made to Optum RX at 800-711-4555.		**Prior Authorization Process for STELARA®:**	
Payer Provided Reimbursement Codes*: PREFILLED SYRINGE: The specialty pharmacy provider will bill Pharmacy Benefits for STELARA 90mg Prefilled Syringe subQ every 8 weeks.		**Payer Provided Reimbursement Codes*:** PREFILLED SYRINGE: This benefit is not available for STELARA 90mg Prefilled Syringe.	
Additional Instructions: The patient is in initial coverage and is responsible for the 41% coinsurance up to the coverage gap and then is responsible for 40% coinsurance up to the out of pocket. Once the total out of pocket is met, catastrophic coverage is 5%. The preferred specialty pharmacy is Briova at phone 800-850-9122 and fax 800-218-3221. There are no mail order benefits for Stelara. Benefits are also available when shipping to the provider's office.		**Additional Instructions:**	
Deductible (Individual):	**Met:**	**Deductible (Individual):**	**Met:**
Deductible (Family):	**Met:**	**Deductible (Family):**	**Met:**
Deductible (Pharmacy):	**Met:**	**Out-of-Pocket Maximum:**	**Met:**
Out-of-Pocket Maximum: $4950.00	**Met:** $117.00	**Lifetime Maximum:**	**Met:**
Lifetime Maximum:	**Met:**	**Benefit Cap:**	**Met:**
Benefit Cap:	**Met:**	**Co-pay for Office Visit:**	
Co-pay for Office Visit:		**Co-pay for STELARA®:**	
Co-pay for Mail Order:			
Co-pay for Retail:			

Medical Buy & Bill Benefits

Major Medical Physician Purchase (Buy & Bill) Coverage for STELARA® Available:

Prior Authorization Required:

Prior Authorization Process:

Payer Provided Reimbursement Codes*: PREFILLED SYRINGE: The benefit for 90mg Prefilled Syringe is available upon request.

Claims Address for Physician Claims:

Additional Instructions: Benefits available upon request.

Deductible (Individual):	**Met:**	**Benefit Cap:**	**Met:**
Deductible (Family):	**Met:**	**Co-pay for Office Visit:**	
Out-of-Pocket Maximum:	**Met:**	**Co-pay for STELARA®:**	
Lifetime Maximum:	**Met:**		

Patient ID: AA00UCLA and **Case ID:** 180829507

*These codes have been provided by the payer without edit and are not a representation of the condition or diagnosis of the patient. It is the provider's responsibility to determine and represent on any claim for reimbursement the patient's accurate condition or diagnosis.

Before prescribing STELARA®, please see full Prescribing Information and Medication Guide, available at JanssenCarePath.com.

OPTUMRx

OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.
Visit go.covermymeds.com/OptumRx to begin using this free service.
Please note: All information below is required to process this request.
Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Stelara® Prior Authorization Request Form (Page 1 of 2)

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)

Member Name: Sherryl Manzo		
Insurance ID#: 0102883881		
Date of Birth: 05/20/1949		
Street Address: 120 Smith Hill Dr		
City: Suffern	State: NY	Zip: 10901
Phone: (561)964-2132		

Provider Information (required)

Provider Name: Alan Goldfischer		
NPI#: 1518980093	Specialty: Gastroenterology	
Office Phone: (845)703-8806		
Office Fax: (845)615-4002		
Office Street Address: 30 Hatfield Ln Ste 107		
City: Goshen	State: NY	Zip: 10924

Medication Information (required)

Medication Name: Stelara	Strength: 90 MG / Dosage Form: PFS
☒ Check if requesting **brand**	Directions for Use: 1 pfs every 56 days
☐ Check if request is for **continuation of therapy**	

Clinical Information (required)

Select the diagnosis below:

- ☐ Active psoriatic arthritis
- ☒ Moderately to severely active Crohn's disease
- ☐ Moderate to severe plaque psoriasis
- ☐ Other diagnosis: _____ ICD-10 Code(s): K50.90

Clinical Information:

Is this request for continuation of prior Stelara therapy? ☐ **Yes** ☐ **No**

Document patient's weight: _____ (lbs/kg) Date: _____

For active psoriatic arthritis requesting 90mg/mL dose, does the patient have co-existent moderate to severe psoriasis? ☐ **Yes** ☐ **No**

Select if Stelara will be used in combination with the following:

- ☐ Biologic DMARD [e.g., Enbrel (etanercept), Humira (adalimumab), Cimzia (certolizumab), Simponi (golimumab)]
- ☐ Janus kinase inhibitor [e.g., Xeljanz (tofacitinib)]
- ☐ Phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)]
- ☐ Not in combination with a biologic DMARD, Janus kinase inhibitor or PDE4 inhibitor

Select if Stelara is prescribed by or in consultation with one of the following specialists:

☐ Dermatologist ☒ Gastroenterologist ☐ Rheumatologist

Select if the patient has history of failure, contraindication, or intolerance to the following:

☐ Cimzia ☐ Cosentyx ☐ Enbrel ☐ Humira ☐ Remicade (For intravenous Stelara requests)

For moderately to severely active Crohn's disease, also answer the following:

Does the patient have history of failure, contraindication, or intolerance to treatment with at least one tumor necrosis factor (TNF) blockers [e.g., Remicade/Infectra (Infliximab), Humira (adalimumab), Cimzia (certolizumab)]? ☒ **Yes** ☐ **No**

Does the patient have history of failure, contraindication, or intolerance to treatment with at least one immunomodulator or corticosteroid [e.g., Purinethol (6-mercaptopurine), Imuran (azathioprine), Sandimmune (cyclosporine A), Prograf (tacrolimus), MTX/Trexall/Rheumatrex (methotrexate)]? ☒ **Yes** ☐ **No**

Is Stelara to be administered as an intravenous induction dose? ☐ **Yes** ☐ **No**

If using intravenous Stelara, select the dose below to verify the Stelera induction dosing is in accordance with the United States Food and Drug Administration approved labeled dosing for Crohn's disease:

- ☐ 260 mg for patients weighing 55 kg or less
- ☐ 390 mg for patients weight more than 55 kg to 85 kg
- ☐ 520 mg for patients weighing more than 85 kg

Office use only: Stelara_CMS_2017Jul-W

OPTUMRx®

Stelara® Prior Authorization Request Form (Page 2 of 2)

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Reauthorization:

If this is a reauthorization request, answer the following questions:

Is there documentation the patient has had a positive clinical response to Stelara therapy? ☐ **Yes** ☐ **No**

Select if Stelara will be used in combination with the following:

- ☐ Biologic DMARD [e.g., Enbrel (etanercept), Humira (adalimumab), Cimzia (certolizumab), Simponi (golimumab)]
- ☐ Janus kinase inhibitor [e.g., Xeljanz (tofacitinib)]
- ☐ Phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)]
- ☐ Not in combination with a biologic DMARD, janus kinase inhibitor or PDE4 inhibitor

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: This request may be denied unless all required information is received.
If the patient is not able to meet the above standard prior authorization requirements, please call 1-800-711-4555.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

Office use only: Stelara_GMS_2017Jul-W