

## PRIOR AUTHORIZATION REQUEST FORM Pyzchiva (ustekinumab-ttwe) and Biosimilars

**For authorization, please answer each question and fax this form PLUS chart notes back to RealRx Medicaid Prior Authorization Department at 385-425-4052.**

**Failure to submit clinical documentation to support this request will result in a dismissal of the request.**

If you have prior authorization questions, please call Pharmacy Customer Service for assistance.

- Healthy U: 855-856-5694
- Healthy U CHIP: 855-203-3633
- Health Choice Utah: 855-864-1404

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:

Height/Weight:

**Preferred:** Pyzchiva, Steqeyma

**Non-preferred:** Imuldosa, Otulfi, Selarsdi, Stelara, Wezlana, Yesintek

Product Requested: \_\_\_\_\_

Directions for Use: \_\_\_\_\_

PART I: Criteria for Approval: (All of the following criteria must be met) - Then move to PART II	Yes	No
1. Which medication is being requested? <input type="checkbox"/> Pyzchiva <input type="checkbox"/> Steqeyma <input type="checkbox"/> Stelara brand or other biosimilar	<input type="checkbox"/>	<input type="checkbox"/>
2. Is the medication being prescribed by or in consultation with a provider specializing in the disease treatment?	<input type="checkbox"/>	<input type="checkbox"/>
3. Does the patient have any of the following diagnoses? (check the applicable) <input type="checkbox"/> Crohn's Disease (CD) <input type="checkbox"/> Plaque Psoriasis (PsO) <input type="checkbox"/> Psoriatic Arthritis (PsA) <input type="checkbox"/> Ulcerative Colitis (UC) <input type="checkbox"/> Other - Off Label or Compendia Use (specify): _____	<input type="checkbox"/>	<input type="checkbox"/>
4. Does the requested medication and diagnosis follow FDA-approved age, dosing, monitoring and contraindications? If answer is No, go to Part II, section 5	<input type="checkbox"/>	<input type="checkbox"/>
5. Does the provider attest that the patient is not taking concurrent treatment or that the medication will not be used in combination with other TNF-inhibitor, biologic response modifier or other biologic DMARDs, Janus kinase Inhibitors, or Phosphodiesterase 4 inhibitor (i.e., apremilast, tofacitinib, baricitinib) as verified by prescriber attestation, member medication fill history, or submitted documentation?	<input type="checkbox"/>	<input type="checkbox"/>
6. Has the patient tried and failed, had an intolerance to, or has a contraindication to the preferred TNF, if applicable?	<input type="checkbox"/>	<input type="checkbox"/>

### PART II: Select and fill out applicable sections:

#### Section 1: Additional criteria for Crohn's Disease (CD) (All of the following criteria must be met)

1. Is the patient at least 18 years of age or older?	<input type="checkbox"/>	<input type="checkbox"/>
2. Does the patient have a diagnosis of moderately to severely active Crohn's Disease as confirmed by applicable testing such as diagnostic imaging, inflammatory biomarker, or disease activity scale and supported by description of baseline symptoms/labs present in the chart notes?	<input type="checkbox"/>	<input type="checkbox"/>
<b>Section 2: Additional criteria for Plaque Psoriasis (PsO) (All of the following criteria must be met)</b>		
1. Is the patient at least 6 years of age or older?	<input type="checkbox"/>	<input type="checkbox"/>
2. Has the patient been diagnosed with moderate to severe plaque psoriasis involving greater than 3% body surface area?	<input type="checkbox"/>	<input type="checkbox"/>
3. If less than 3% of the body is involved, is there scalp, palmar, foot, or groin involvement causing significant disability?	<input type="checkbox"/>	<input type="checkbox"/>
4. Has the member tried and failed at least ONE of the following medications for at least 3 months, or is contraindicated to all 3, if clinically appropriate? <input type="checkbox"/> methotrexate <input type="checkbox"/> cyclosporine <input type="checkbox"/> acitretin therapy	<input type="checkbox"/>	<input type="checkbox"/>
<b>Section 3: Additional criteria for Psoriatic Arthritis (PsA) (All of the following criteria must be met)</b>		
1. Is the patient at least 6 years of age or older?	<input type="checkbox"/>	<input type="checkbox"/>
2. Does the patient have a diagnosis of active psoriatic arthritis demonstrated by description of baseline symptoms present in the chart notes?	<input type="checkbox"/>	<input type="checkbox"/>
3. Has the patient had an adequate trial and failure of at least ONE of the following disease-modifying antirheumatic drugs (DMARDs) for at least 3 months, unless all are contraindicated: methotrexate, leflunomide, sulfasalazine, azathioprine, if clinically appropriate?	<input type="checkbox"/>	<input type="checkbox"/>
<b>Section 4: Additional criteria for Ulcerative Colitis (UC) (All of the following criteria must be met)</b>		
1. Is the patient at least 18 years of age or older?	<input type="checkbox"/>	<input type="checkbox"/>
2. Does the patient have a diagnosis of moderately to severely active Ulcerative Colitis as confirmed by applicable testing such as diagnostic imaging, inflammatory biomarker, or disease activity scale and supported by description of baseline symptoms/labs present in the chart notes?	<input type="checkbox"/>	<input type="checkbox"/>
3. Has the member had an adequate trial and failure of at least ONE of the following for at least 2 months, or has a contraindication to all? <input type="checkbox"/> High dose oral 5-aminosalicylic acid drug <input type="checkbox"/> Topical 5-aminosalicylic acid drug	<input type="checkbox"/>	<input type="checkbox"/>
<b>Section 5: Other - Off Label or Compendia Use of FDA-Approved Drugs Additional Criterion:</b>		
1. Does the clinical documentation show an adequate trial and failure with at least ONE FDA-labeled and Medicaid preferred medication, if applicable?	<input type="checkbox"/>	<input type="checkbox"/>
2. Provider attest the requested drug is being used for a medically accepted indication that is supported by information from the appropriate compendia* of current literature. Including at least (1) major multi-site study or three (3) smaller studies published in JAMA, NEJM, Lancet, or other peer review specialty medical journals in the most recent years? * Compendia use must be recommended by generally accepted compendia such as American Hospital Formulary Service Drug Information (AHFS), United States Pharmacopeia-Drug Information (USP-DI), the Micromedex Information System, Pediatric and Neonatal Lexi-Drugs, or clinical guidelines.	<input type="checkbox"/>	<input type="checkbox"/>
<b>PART III: Non-Preferred adalimumab Criteria (PART 1 &amp; PART II MUST also be met)</b>		
1. For requests of brand Stelara or any non-preferred biosimilar other than the preferred above, has the patient tried ALL of the ustekinumab preferred products?	<input type="checkbox"/>	<input type="checkbox"/>
<b>Reauthorization</b>		
1. Has the provider submitted an updated letter with medical justification and updated chart notes demonstrating positive clinical response?	<input type="checkbox"/>	<input type="checkbox"/>
<b>PRESCRIBER CERTIFICATION</b>		
I hereby certify this treatment is indicated, necessary and meets the guidelines for use.		
Physician's Signature:	Date:	

**Initial Authorization:** Up to six (6) months

**Reauthorization:** Up to one (1) year

**\*\* Failure to submit clinical documentation to support this request will result in a dismissal of the request.\*\***

Policy: PHARM-HYB-185  
Origination Date: 01/01/2026  
Reviewed/Revised Date:  
Next Review Date:  
Current Effective Date: 01/01/2026

**Confidentiality Notice**

This document and any accompanying document contain confidential information and is intended for the use of the individual or entity named on this transmission sheet. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or the taking of any action in reliance on the contents of this information is strictly prohibited and the document should be returned to this office immediately. If you have received this facsimile in error, please notify us by telephone immediately and destroy document received.