[Insert Physician Letterhead]

[Insert Name of Medical Director] Re: Member Name: [Insert Member Name]

[Insert Payer Name] Member Number: [Insert Member Number]

[Insert Address] Group Number: [Insert Group Number]

[Insert City, State ZIP]

**REQUEST:** Authorization for treatment with STELARA® (ustekinumab)

**DIAGNOSIS:** [Insert Diagnosis] [Insert ICD]

**DOSE AND FREQUENCY:** [Insert Dose & Frequency]

**REQUEST TYPE:** ☐ Standard ☐ EXPEDITED

Dear [Insert Name of Medical Director or name of individual responsible for prior authorization],

I am writing to request a **formulary exception** for the above-mentioned patient to receive treatment with STELARA®
[45 mg vial, 45 mg prefilled syringe, or 90 mg prefilled syringe] for active psoriatic arthritis. My request is supported by the following:

**Summary of Patient’s Diagnosis**

[Insert patient’s diagnosis, date of diagnosis, lab results and date, current condition]

**Summary of Patient’s History**

[Insert:

* Previous therapies/procedures, including dose and duration, response to those interventions
* Description of patient’s recent symptoms, including if patient has co-existent moderate-to-severe plaque psoriasis
* Site of medical service—include site type (eg, inpatient, hospital outpatient, outpatient clinic, private practice,
or other) and rationale (eg, compliance or closely monitoring). Note: STELARA® for active psoriatic arthritis may be administered at home if deemed appropriate by the patient’s Healthcare Provider
* Rationale for not using drugs that are on the plan's formulary
* Summary of your professional opinion of the patient’s likely prognosis or disease progression without treatment
with STELARA®

Note: Exercise your medical judgment and discretion when providing a diagnosis and characterization of the patient’s medical condition.]

**Rationale for Treatment**

[Insert summary statement for rationale for treatment such as: Considering the patient’s history, condition, and the full Prescribing Information supporting uses of STELARA®, I believe treatment with STELARA® at this time is medically necessary, and should be a covered and reimbursed service.]

[You may consider including documents that provide additional clinical information to support the recommendation for STELARA® for this patient, such as the full Prescribing Information, peer-reviewed journal articles, or clinical guidelines.]

[Given the urgent nature of this request,] please provide a timely authorization. Contact my office at [Insert Phone Number] if I can provide you with any additional information.

Sincerely,

[Insert Healthcare Provider's Name and Participating Provider Number]

Enclosures [Include full Prescribing Information and the additional support noted above]