

Medicare Part D – 2016**Prior Authorization Group Description:**

STELARA

Covered Uses:

All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria:**Required Medical Information:**

MAINTENANCE REQUESTS: Maintained on therapy with positive response.

Age Restrictions:**Prescriber Restrictions:**

PSORIATIC ARTHRITIS, PLAQUE PSORIASIS: Rheumatologist or Dermatologist.

Coverage Duration:

Length of Benefit.

Other Criteria:

PLAQUE PSORIASIS: Failure or clinically significant adverse effects to ONE of the following: methotrexate, cyclosporine, or acitretin. PSORIATIC ARTHRITIS: Failure or clinically significant adverse effects to methotrexate unless contraindicated