

Special Authorization Request Form, for:

STELARA (*ustekinumab*)

The purpose of this form is to obtain medical information required to assess your request for a drug on the Special Authorization (SA) list of the Reformulary. Please ensure that all information, including contact information, is complete. Completing this form is not a guarantee of approval.

PART 1: COMPLETE THIS INFORMATION

Information about plan member

First name: _____ Last name: _____

Group number: _____ Certificate number: _____

Date of birth (DD/MM/YY): _____ Gender: _____

Address: _____

City/Town: _____ Province: _____ Postal code: _____

Email: _____ Phone: _____

COORDINATION OF BENEFITS

Coverage through another health benefit plan or provincial plan

Do you or your dependents have drug coverage through another health benefits, insurance company or provincial plan? Yes No

If yes, provide the following: Name of plan member: _____

Policy/Plan number: _____ Certificate number: _____

Patient assistance program

Have you enrolled in a patient assistance program? Yes No

If yes, provide your patient assistance program ID number: _____

Provide the patient assistance program:

Contact name: _____ Phone: _____

PART 2: TO BE COMPLETED BY YOUR DOCTOR (PHYSICIAN)

Physician Information

First name: _____ Last name: _____

License: _____ Phone: _____

Address: _____

City/Town: _____ Province: _____ Postal code: _____

Physician's signature: _____

(confirming the below information to be correct)

Drug being requested through Special Authorization

New request Request for continuation of therapy

DIN: _____ Product name: _____

Strength: _____ Dosage: _____

Site of Administration

- Home Private clinic Hospital
 Doctor's office Cancer centre LTC facility

CLINICAL INFORMATION

Diagnosis

- Plaque Psoriasis
 Plaque Psoriasis (pediatric patients)

Note:

STELARA (*ustekinumab*) SC will no longer be covered for the treatment of Psoriatic Arthritis. The following treatments will be considered for coverage: biosimilars of *infliximab* (INFLECTRA, RENFLEXIS, AVSOLA), *etanercept* (ERELZI), *adalimumab* (AMGEVITA, HULIO); or biologic drug *cerolizumab* (CIMZIA).

STELARA (*ustekinumab*) SC and IV will no longer be covered for the treatment of Crohn's Disease or Ulcerative Colitis. The following treatments will be considered for coverage: biosimilars of *infliximab* (INFLECTRA, RENFLEXIS, AVSOLA) or *adalimumab* (AMGEVITA, HULIO).

CLINICAL INFORMATION (cont.)

Physician specialty

- Dermatologist
- Pediatrician with experience in treating adolescent plaque psoriasis

Criteria for initial coverage, confirm the following:

FOR PLAQUE PSORIASIS

- Patient is 18 years of age or older; and
- Patient diagnosed with severe Plaque Psoriasis (PASI score ≥ 12 and BSA involvement $\geq 10\%$); and
- Patient is intolerant to, or has tried and failed to respond to adequate trials of either biosimilars of *infliximab*, *etanercept*, or *adalimumab*, or CIMZIA (*certolizumab pegol*), or BIMZELX (*bimekizumab*); and
- Patient has failed to respond to, is intolerant to, or unable to access at least a 12-week trial of phototherapy

NOTE: Duration of initial approval is 12 weeks

Important note: Patient should be monitored to determine if continuation of therapy beyond 12 weeks is required. Patient not responding adequately at 12 weeks should have treatment discontinued.

FOR PLAQUE PSORIASIS (PEDIATRIC PATIENTS)

- Patient is between 6 - 17 years of age; and
- Patient must be diagnosed with severe Plaque Psoriasis (PASI score ≥ 12 and BSA involvement $\geq 10\%$); and
- Patient is intolerant to, has contraindications to, or has inadequate response to either *methotrexate*, *cyclosporine* or *acitretin* after at least a 6-month trial; and
- Patient has failed to respond to, is intolerant to or unable to access at least a 12-week trial of phototherapy

NOTE: Duration of initial approval is 12 weeks

Important note: Patient should be monitored to determine if continuation of therapy beyond 12 weeks is required. Patient not responding adequately at 12 weeks should have treatment discontinued.

Request for continuation of therapy, confirm the following:

FOR PLAQUE PSORIASIS

- Patient demonstrates continued therapeutic benefit, outweighing any potential risks. Specifically, after 3 months of therapy patients who respond to therapy should have:
 - at least a 50% reduction in PASI; and
 - at least a 50% reduction in BSA involvement; and
 - at least a 5 point reduction in DLQI score

NOTE: Duration of continued approval is 1 year

FOR PLAQUE PSORIASIS (PEDIATRIC PATIENTS)

- Patient demonstrates continued therapeutic benefit, outweighing any potential risks. Specifically, after 3 months of therapy patients who respond to therapy should have:
 - at least a 50% reduction in PASI; and
 - at least a 5 point reduction in CDLQI (Children’s Dermatology Life Quality Index) score

NOTE: Duration of continued approval is 1 year

SPECIAL NOTES

Describe any intolerances to therapy: _____

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

Update: June 2023