Stelara® (ustekinumab) Specialty Medication Precertification Request

(All fields must be completed and legible for precertification review.)

Aetna Precertification Notification
Phone: 1-855-240-0535
FAX: 1-877-269-9916
IV Formulation only:
Phone: 1-866-752-7021
FAX: 1-888-267-3277

For Medicare Advantage Part B:
Please Use Medicare Request Form

Please indicate: ☐ Start of treatment: Start date ____/____/____
☐ Continuation of therapy: Date of last treatment ____/____/____

Precertification Requested By: _____ Phone: _____ Fax: _____

A. PATIENT INFORMATION

First Name:	Last Name:	DOB:	
Address:	City:	State:	ZIP:
Home Phone:	Work Phone:	Cell Phone:	Email:
Current Weight: _____ lbs or _____ kgs Height: _____ inches or _____ cms		Allergies:	

B. INSURANCE INFORMATION

Aetna Member ID #: _____
Group #: _____
Insured: _____

Does patient have other coverage? ☐ Yes ☐ No
If yes, provide ID#: _____ Carrier Name: _____
Insured: _____

Medicare: ☐ Yes ☐ No If yes, provide ID #: **Medicaid:** ☐ Yes ☐ No If yes, provide ID #:

C. PRESCRIBER INFORMATION

First Name:		Last Name: *(Check One):* ☐ M.D. ☐ D.O. ☐ N.P. ☐ P.A.			
Address:		City:		State:	ZIP:
Phone:	Fax:	St Lic #:	NPI #:	DEA #:	UPIN:
Provider Email:		Office Contact Name:		Phone:	

Specialty *(Check one):* ☐ **Dermatologist** ☐ **Gastroenterologist** ☐ **Rheumatologist** ☐ **Other**: _____

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:
☐ Self-administered ☐ Physician's Office
☐ Outpatient Infusion Center Phone: _____
Center Name: _____
☐ Home Infusion Center Phone: _____
Agency Name: _____
☐ Administration code(s) (CPT): _____
Address: _____

Dispensing Provider/Pharmacy: *Patient Selected choice*
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Other _____
Name: _____
Address: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____

E. PRODUCT INFORMATION

Request is for Stelara (ustekinumab) *(Check One):* ☐ 45mg ☐ 90mg ☐ 130mg/26 ml (5mg/ml) Route:_____ Frequency: _____

F. DIAGNOSIS INFORMATION - Please indicate primary ICD Code and specify any other any other where applicable (*).

Primary ICD Code: _____ Secondary ICD Code: _____ Other ICD Code: _____

G. CLINICAL INFORMATION - Required clinical information must be completed for ALL precertification requests.

For All Requests (clinical documentation required for all requests):

☐ Yes ☐ No Will the requested drug be used in combination with any other biologic (e.g., Humira) or targeted synthetic disease modifying antirheumatic drug (DMARD) (e.g., Olumiant, Otezla, Xeljanz)?

☐ Yes ☐ No Has the patient ever received (including current utilizers) a biologic (e.g., Humira) or targeted synthetic DMARD (e.g., Olumiant, Xeljanz) associated with an increased risk of tuberculosis?

→ ☐ Yes ☐ No Has the patient been tested for TB with a PPD test, interferon-release assay (IGRA) or chest x-ray within 6 months of initiating a biologic therapy?

→ (Check all that apply): ☐ PPD test ☐ interferon-gamma assay (IGRA) ☐ chest x-ray
Please enter the results of the TB test: ☐ positive ☐ negative ☐ unknown
If positive, Does the patient have latent or active TB? ☐ latent ☐ active ☐ unknown
If latent TB, ☐ Yes ☐ No Has treatment for latent tuberculosis (TB) infection been initiated or completed?
→ Please select: ☐ treatment initiated ☐ treatment completed

→ ☐ Yes ☐ No Does the patient have risk factors for tuberculosis (TB) (e.g., persons with close contact to people with infectious TB disease; persons who have recently immigrated from areas of the world with high rates of TB [e.g., Africa, Asia, Eastern Europe, Latin America, Russia]; children less than 5 years of age who have a positive TB test; groups with high rates of TB transmission [e.g., homeless persons, injection drug users, persons with HIV infection], or persons who work or reside with people who are at an increased risk for active TB [e.g., hospitals, long-term care facilities, correctional facilities, homeless shelters])?

→ ☐ Yes ☐ No Has the patient been tested for tuberculosis (TB) within the previous 12 months?
→ (Check all that apply): ☐ PPD test ☐ interferon-gamma assay (IGRA) ☐ chest x-ray
Please enter the results of the TB test: ☐ positive ☐ negative ☐ unknown
If positive, Does the patient have latent or active TB? ☐ latent ☐ active ☐ unknown
If latent TB, ☐ Yes ☐ No Has treatment for latent tuberculosis (TB) infection been initiated or completed?
→ Please select: ☐ treatment initiated ☐ treatment completed

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G. CLINICAL INFORMATION - Required clinical information must be completed for ALL precertification requests.

Crohn's disease

Please indicate one time loading dose: _____ Please indicate maintenance dose: _____ frequency: _____ weeks

☐ Yes ☐ No Has the patient been diagnosed with moderately to severely active Crohn's disease (CD)?

→ ☐ Yes ☐ No Has the patient ever received (including current utilizers) a biologic (e.g., Humira) indicated for Crohn's disease?

→ ☐ Yes ☐ No Has the patient tried and had an inadequate response to at least one conventional therapy option?

→ ☐ Yes ☐ No Does the patient have a contraindication or intolerance to at least one conventional therapy option (e.g.,azathioprine [Azasan, Imuran], budesonide [Entocort EC], ciprofloxacin [Cipro], mercaptopurine [Purinethol], methylprednisolone [Solu-Medrol], methotrexate, metronidazole [Flagyl], prednisone, sulfasalazine [Azulfidine, Sulfazine], rifaximin [Xifaxan], tacrolimus)?

→ Please select: ☐ Sulfasalazine (Azulfidine, Sulfazine) ☐ Metronidazole (Flagyl) ☐ Prednisone ☐ Ciprofloxacin (Cipro) ☐ Budesonide (Entocort EC) ☐ Azathioprine (Azasan, Imuran) ☐ Mercaptopurine (Purinethol) ☐ Methotrexate intramuscular (IM) or subcutaneous (SC) ☐ Methylprednisolone (Solu-Medrol) ☐ Rifaximin (Xifaxan) ☐ Tacrolimus

Plaque psoriasis

Please indicate loading dose at weeks 0 and 4: _____ Please indicate maintenance dose: _____ Frequency: _____ weeks

☐ Yes ☐ No Has the patient been diagnosed with moderate to severe plaque psoriasis?

☐ Yes ☐ No Has the patient ever received (including current utilizers) Otezla or a biologic (e.g, Humira) indicated for the treatment of moderate to severe plaque psoriasis?

→ ☐ Yes ☐ No Are crucial body areas (e.g., hands, feet, face, neck, scalp, genitals/groin, intertriginous areas) affected?

→ Please indicate the percentage of body surface area (BSA) affected (prior to starting the requested medication): _____%

<u>If less than 10% of BSA:</u>

☐ Yes ☐ No Has the patient experienced an inadequate response, or has an intolerance to phototherapy (e.g., UVB, PUVA) or pharmacologic treatment with methotrexate, cyclosporine or acitretin?

→ ☐ Yes ☐ No Does the patient have a clinical reason to avoid pharmacologic treatment with methotrexate, cyclosporine and acitretin?

→ Please indicate clinical reason to avoid pharmacologic treatment:

☐ Clinical diagnosis of alcohol use disorder, alcoholic liver disease or other chronic liver disease

☐ Breastfeeding ☐ Cannot be used due to risk of treatment-related toxicity ☐ Drug interaction

☐ Pregnancy or currently planning pregnancy

☐ Significant comorbidity prohibits use of systemic agents (e.g., liver or kidney disease, blood dyscrasias, uncontrolled hypertension)

☐ Other, please explain: _____

Psoriatic arthritis with co-existent plaque psoriasis

Please indicate loading dose at weeks 0 and 4: _____ Please indicate maintenance dose: _____ frequency: _____ weeks

☐ Yes ☐ No Has the patient been diagnosed with active psoriatic arthritis (PsA)?

Ulcerative colitis

Please indicate one time loading dose: _____ Please indicate maintenance dose: _____ frequency: _____ weeks

☐ Yes ☐ No Has the patient been diagnosed with moderately to severely active ulcerative colitis (UC)?

→ ☐ Yes ☐ No Has the patient ever received (including current utilizers) a biologic (e.g., Humira) or targeted synthetic disease modifying drug (e.g., Xeljanz) indicated for moderately to severely active ulcerative colitis?

→ ☐ Yes ☐ No Has the patient tried and had an inadequate response to at least one conventional therapy option?

→ ☐ Yes ☐ No Does the patient have a contraindication or intolerance to at least one conventional therapy option (e.g., azathioprine [Azasan, Imuran], corticosteroid [e.g., hydrocortisone, methylprednisolone, prednisone, cyclosporine, [Sandimmune], mesalamine [Asacol, Lialda, Pentasa, Canasa, Rowasa], balsalazide, olsalazine, mercaptopurine [Purinethol], sulfasalazine, tacrolimus [Prograf], metronidazole/ciprofloxacin [for pouchitis only])?

→ Please select: ☐ Azathioprine (Azasan, Imuran) ☐ Corticosteroid (e.g., hydrocortisone [Cortifoam, Colocort, Solu-Cortef, Cortef], methylprednisolone [Medrol, Solu-Medrol], prednisone) ☐ Cyclosporine (Sandimmune) ☐ Mesalamine (e.g., Asacol, Lialda, Pentasa, Canasa,Rowasa) balsalazide, olsalazine ☐ Mercaptopurine (Purinethol) ☐ Sulfasalazine ☐ Tacrolimus (Prograf) ☐ Metronidazole (Flagyl) or Ciprofloxacin (Cipro) (for pouchitis only)

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G. CLINICAL INFORMATION - Required clinical information must be completed for ALL precertification requests.

For Continuation Requests (clinical documentation required for all requests):

Please indicate maintenance dose: _____ frequency: _____ weeks

☐ Yes ☐ No Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program?

☐ Yes ☐ No Has the patient achieved or maintained positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition since starting treatment with the requested drug?

Crohn's disease

☐ Yes ☐ No Has the patient achieved or maintained remission?

Please indicate which of the following has the patient experienced:

☐ Abdominal pain or tenderness ☐ Abdominal mass ☐ Body weight ☐ Diarrhea ☐ Endoscopic appearance of the mucosa ☐ Hematocrit

☐ Improvement on a disease activity scoring tool (e.g., Crohn's Disease Activity Index [CDAI] score) ☐ None of the above

Plaque psoriasis

☐ Yes ☐ No Has the patient experienced a reduction in body surface area (BSA) affected from baseline?

→ ☐ Yes ☐ No Has the patient experienced an improvement in signs and symptoms of the condition from baseline (e.g., itching, redness, flaking, scaling, burning, cracking, pain)?

Psoriatic arthritis with or without co-existent plaque psoriasis

Please indicate which of the following has the patient experienced:

☐ Number of swollen joints ☐ Number of tender joints ☐ Dactylitis ☐ Enthesitis ☐ Skin and/or nail involvement ☐ None of the above

Ulcerative Colitis

☐ Yes ☐ No Has the patient achieved or maintained remission?

Please indicate which of the following has the patient experienced:

☐ Stool frequency ☐ Rectal bleeding ☐ Urgency of defecation ☐ C-reactive protein (CRP) ☐ Fecal calprotectin (FC) ☐ Endoscopic appearance of the mucosa ☐ Improvement on a disease activity scoring tool (e.g., Ulcerative colitis Endoscopic Index of Severity [UCEIS] Mayo Score) ☐ None of the above

H. ACKNOWLEDGEMENT

Request Completed By *(Signature Required):* _____ **Date:** ____/____/____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The plan may request additional information or clarification, if needed, to evaluate requests.