Stelara® (ustekinumab) Specialty Medication Precertification Request

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

Aetna Precertification Notification
Phone: 1-866-752-7021 (TTY: 711)
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)*:* Dose: _____ **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 anti-rheumatic 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 had a tuberculosis (TB) test (e.g., tuberculosis skin test [PPD], interferon-release assay [IGRA], chest x-ray) within 6 months of initiating therapy?

(Check all that apply): ☐ PPD test ☐ interferon-gamma assay (IGRA) ☐ chest x-ray

→ Please enter the results of the tuberculosis (TB) test: ☐ positive ☐ negative ☐ unknown

If positive, please indicate which applies to the patient:
☐ latent TB and treatment for latent TB has been initiated
☐ latent TB and treatment for latent TB has not been initiated
☐ active TB
☐ latent TB and treatment for latent TB has been 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 or fistulizing Crohn's disease (CD)?
☐ Yes ☐ No Is the requested drug being prescribed by or in consultation with a gastroenterologist?
☐ Yes ☐ No Has the patient ever received (including current utilizers) a biologic (e.g., Humira) indicated for Crohn's disease?
→ ☐ Yes ☐ No Does the patient have fistulizing 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 Is the requested drug being prescribed by or in consultation with a dermatologist?
☐ Yes ☐ No Has the patient ever received (including current utilizers) a biologic (e.g., Humira) or targeted synthetic drug (e.g., Sotyktu, Otezla) 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): _____%

If less than 10% of BSA:
☐ 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

Please indicate which of the following applies to the patient:
☐ WITH co-existent plaque psoriasis,
→ ☐ Yes ☐ No Is the plaque psoriasis being treated as the primary diagnosis?
→ Please go to plaque psoriasis section
☐ WITHOUT co-existent plaque psoriasis
☐ Yes ☐ No Has the patient been diagnosed with active psoriatic arthritis (PsA)?
☐ Yes ☐ No Is the requested drug being prescribed by or in consultation with a rheumatologist or dermatologist?
☐ Yes ☐ No Has the patient ever received (including current utilizers) a biologic (e.g., Humira) or targeted synthetic drug (e.g., Rinvoq, Otezla) that is indicated for active psoriatic arthritis?
→ ☐ Yes ☐ No Does the patient have mild to moderate disease?
→ ☐ Yes ☐ No Does the patient have severe disease?
☐ Yes ☐ No Does the patient have enthesitis or predominantly axial disease?
→ ☐ Yes ☐ No Has the patient had an inadequate response to methotrexate, leflunomide, or another conventional synthetic drug (e.g., sulfasalazine) administered at an adequate dose and duration?
→ ☐ Yes ☐ No Has the patient had an intolerance to methotrexate, leflunomide, or another conventional synthetic drug (e.g., sulfasalazine)?
→ ☐ Yes ☐ No Does the patient have a contraindication to methotrexate or leflunomide?
→ ☐ Yes ☐ No Does the patient have a contraindication to another conventional synthetic drug (e.g., sulfasalazine)?
Please indicate the contraindication:
☐ Clinical diagnosis of alcohol use disorder, alcoholic liver disease or other chronic liver disease ☐ History of intolerance or adverse event ☐ Elevated liver transaminases
☐ Interstitial pneumonitis or clinically significant pulmonary fibrosis ☐ Breastfeeding
☐ Renal impairment ☐ Pregnancy or currently planning pregnancy ☐ Myelodysplasia
☐ Blood dyscrasias (e.g., thrombocytopenia, leukopenia, significant anemia)
☐ Hypersensitivity ☐ Significant drug interaction ☐ Other, please explain: _____

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

Immune Checkpoint Inhibitor-Related Toxicity

☐ Yes ☐ No Is the requested drug being prescribed by or in consultation with a hematologist or oncologist?
☐ Yes ☐ No Has the patient experienced an inadequate response to infliximab or vedolizumab?
→ ☐ Yes ☐ No Has the patient experienced an intolerance to infliximab or vedolizumab?
→ ☐ Yes ☐ No Does the patient have a contraindication to infliximab and vedolizumab?
☐ Yes ☐ No Is the requested quantity supported by dosing guidelines found in the compendia or current literature (e.g., Micromedex DrugDex, NCCN compendia, current treatment guidelines)?

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 Is the requested drug being prescribed by or in consultation with a gastroenterologist?
☐ 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 ever been hospitalized for acute severe ulcerative colitis (e.g., continuous bleeding, severe toxic symptoms, including fever and anorexia)?
→ ☐ 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])?
→ 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)

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?
☐ 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?

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.