aetna®

MEDICARE FORM
Stelara® (ustekinumab) Specialty Medication Precertification Request

(Please return **Pages 1 to 3** for precertification of medications.)

For Michigan MMP:
FAX: 1-844-241-2495
PHONE: 1-855-676-5772

For other lines of business:
Please use other form.

Note: Stelara is non-preferred. Preferred products vary based on indication. See section G below.

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: ______________________

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:	

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:
☐ Self-administered ☐ Physician's Office ☐ Home
☐ Outpatient Infusion Center Phone: ____________
Center Name: ____________
☐ Home Infusion Center Phone: ____________
Agency Name: ____________
☐ Administration code(s) (CPT): ____________
Address: ____________
City: ____________ State: ______ ZIP: ______
Phone: ____________ Fax: ____________
TIN: ____________ PIN: ____________
NPI: ____________
Please explain if there are any medical reason(s) why the patient cannot self-inject the requested drug:
____

Dispensing Provider/Pharmacy:
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Mail Order ☐ Other: ________
Name: ____________
Address: ____________
City: ____________ State: ______ ZIP: ______
Phone: ____________ Fax: ____________
TIN: ____________ PIN: ____________
NPI: ____________

E. PRODUCT INFORMATION

Request is for Stelara (ustekinumab) *(Check One):*
☐ 45mg ☐ 90mg **Route**: ____________
Frequency: ____________
HCPCS Code: ____________ ☐ IV ☐ SC

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 Initiation Requests (clinical documentation required for all requests):

Note: Stelara is non-preferred. Entyvio, Inflectra, Remicade, and Simponi Aria are preferred for MA plans. For MAPD plans, Entyvio, Inflectra, and Remicade are preferred for ulcerative colitis and Enbrel, Humira, Otezla, Rinvoq, Skyrizi, and Xeljanz/Xeljanz XR are preferred for other indications. Preferred products vary based on indication.

☐ Yes ☐ No Has the patient had prior therapy with Stelara (ustekinumab) within the last 365 days?
☐ Yes ☐ No Has the patient had a trial and failure, intolerance, or contraindication to any of the following? (select all that apply)
☐ Entyvio (vedolizumab) ☐ Inflectra (infliximab-dyyb) ☐ Remicade (infliximab) ☐ Simponi Aria (golimumab)
☐ Yes ☐ No Has the patient had a trial and failure, intolerance, or contraindication to any of the following? (select all that apply)
☐ Enbrel (etanercept) ☐ Humira (adalimumab) ☐ Otezla (apremilast) ☐ Rinvoq (upadacitinib) ☐ Skyrizi (risankizumab-rzaa)
☐ Xeljanz/Xeljanz XR (tofacitinib)

Please explain if there are any other medical reason(s) that the patient cannot use any of the following preferred products when indicated for the patient's diagnosis (select all that apply)
☐ Entyvio (vedolizumab) ☐ Inflectra (infliximab-dyyb) ☐ Remicade (infliximab) ☐ Simponi Aria (golimumab)
____

Please explain if there are any other medical reason(s) that the patient cannot use any of the following preferred products when indicated for the patient's diagnosis (select all that apply)
☐ Enbrel (etanercept) ☐ Humira (adalimumab) ☐ Otezla (apremilast) ☐ Rinvoq (upadacitinib) ☐ Skyrizi (risankizumab-rzaa)
☐ Xeljanz/Xeljanz XR (tofacitinib)
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Patient First Name	Patient Last Name	Patient Phone	Patient DOB

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

☐ Yes ☐ No Will Stelara (ustekinumab) be given concomitantly with apremilast, tofacitinib, or other biologic DMARDs (e.g., adalimumab, infliximab)?
☐ Yes ☐ No Has the patient been tested for TB with a PPD test, interferon-release assay (IGRAs) or chest x-ray within 6 months of initiation a biologic therapy?
→ (check all that apply): ☐ PPD test ☐ interferon-gamma assay (IGRA) ☐ chest x-ray
Please enter results of the TB test: ☐ positive ☐ negative ☐ unknown
If positive, does the patient have latent or active TB? ☐ latent ☐ active
If latent TB, ☐ **Yes** ☐ **No** **Will TB treatment be started before initiation of therapy with Stelara (ustekinumab)?**

Crohn's Disease
☐ Yes ☐ No Does the patient have a diagnosis of fistulizing Crohn's disease?
→ Please indicate how long the patient has been diagnosed with fistulizing Crohn's disease:
☐ Yes ☐ No Does the patient have a diagnosis of Crohn's disease?
→ Please indicate the severity of the patient's disease: ☐ mild ☐ moderate ☐ severe
☐ Yes ☐ No Does the patient have a documented diagnosis of active Crohn's disease?
→ Please select all signs/symptoms that apply:
☐ abdominal pain ☐ arthritis ☐ bleeding ☐ diarrhea ☐ internal fistulae ☐ intestinal obstruction
☐ megacolon ☐ perianal disease ☐ spondylitis ☐ weight loss ☐ None of the above
☐ Yes ☐ No Have the Crohn's disease symptoms remained active despite treatment with 6-mercaptopurine, azathioprine, or corticosteroids?
→ Please check all medications that apply: ☐ 6-mercaptopurine ☐ azathioprine
☐ corticosteroids- please identify: ☐ prednisone ☐ hydrocortisone ☐ methylprednisolone ☐ Other: ______________
☐ Yes ☐ No Will the initial (induction) dose of Stelara (ustekinumab) be administered intravenously?
☐ Yes ☐ No Will all doses after the initial dose be administered subcutaneously?

Plaque Psoriasis (Adult and Pediatric)
☐ Yes ☐ No Is there clinical documentation of chronic disease?
→ Please indicate the severity of the patient's plaque psoriasis: ☐ mild ☐ moderate ☐ severe
☐ Yes ☐ No Is there evidence that the disease is active?
☐ Yes ☐ No Is the patient a candidate for systemic therapy or phototherapy?
→ Please select: ☐ phototherapy ☐ systemic therapy ☐ phototherapy and systemic therapy
Please provide the patient's Psoriasis Area and Severity Index (PASI) score: _____
Please indicate the percentage of body surface area affected by plaque psoriasis: _____%
☐ Yes ☐ No Does the plaque psoriasis affect sensitive areas? ***If yes***, please select: ☐ hands ☐ feet ☐ face ☐ genitals

Adult
☐ Yes ☐ No Was a trial of systemic conventional DMARD(s) (e.g., methotrexate, acitretin, or cyclosporine) ineffective?
→ ☐ Yes ☐ No Was the trial with systemic conventional DMARD(s) not tolerated?
☐ Yes ☐ No Are systemic conventional DMARD(s) contraindicated?
→ Please select: ☐ acetretin ☐ cyclosporine ☐ methotrexate ☐ mycophenolate ☐ Other, please explain: ______________________
☐ Yes ☐ No Was a trial with phototherapy ineffective?
→ ☐ Yes ☐ No Was the trial with phototherapy not tolerated?
☐ Yes ☐ No Is phototherapy contraindicated?
→ Please check all that apply: ☐ Psoralens (methoxsalen, trioxsalen) with UVA light (PUVA)
☐ UVB with coal tar or dithranol
☐ UVB (standard or narrow band)
☐ Home UVB
☐ None of the above
Please indicate the length of trial: ☐ Less than 1 month ☐ 1 month ☐ 2 months ☐ 3 months or greater

Pediatric
☐ Yes ☐ No Was a trial with phototherapy ineffective, not tolerated, or contraindicated?
→ Please check all that apply: ☐ Psoralens (methoxsalen, trioxsalen) with UVA light (PUVA)
☐ UVB with coal tar or dithranol
☐ UVB (standard or narrow band)
☐ Home UVB
☐ None of the above
Please indicate the length of trial: ☐ Less than 1 month ☐ 1 month ☐ 2 months ☐ 3 months or greater

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Psoriatic Arthritis

☐ Yes ☐ No Does the patient have co-existent moderate to severe plaque psoriasis?
☐ Yes ☐ No Is there evidence that the disease is active?
☐ Yes ☐ No Does the patient have **axial** psoriatic arthritis?
→ ☐ Yes ☐ No Was the treatment with 2 or more non-steroidal anti-inflammatory drugs (NSAIDs) ineffective?
→ Please provide the names and length of treatment:
NSAID #1: ____________________
NSAID #2: ____________________

☐ Yes ☐ No Does the patient have **non-axial** psoriatic arthritis?
→ ☐ Yes ☐ No Does the patient have severe disease at presentation, defined as severe disability at onset with erosive disease involving multiple joints?
→ ☐ Yes ☐ No Was the treatment with methotrexate ineffective?
→ ☐ Yes ☐ No Was treatment with methotrexate not tolerated or contraindicated?
→ Please select: ☐ not tolerated ☐ contraindicated
☐ Yes ☐ No Was treatment with another conventional DMARD ineffective?
→ Please select: ☐ cyclophosphamide ☐ cyclosporine ☐ hydroxychloroquine ☐ leflunomide ☐ sulfasalazine ☐ Other, please explain: __________

Ulcerative Colitis

☐ Yes ☐ No Has the patient been diagnosed with moderately to severely active ulcerative colitis (UC)?
→ ☐ Yes ☐ No Has the patient previously received a biologic 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., budesonide, hydrocortisone [Entocort, Uceris], methylprednisolone, prednisone, cyclosporine [Sandimmune], mesalamine [Asacol, Lialda, Pentasa, Canasa, Rowasa], mercaptopurine [Purinethol], sulfasalazine, tacrolimus [Prograf], metronidazole/ciprofloxacin [for pouchitis only])?
→ Please select: ☐ Azathioprine [Azasan, Imuran] ☐ Corticosteroid (e.g., budesonide [Entocort, Uceris], hydrocortisone [Cortifoam, Colocort, Solu-Cortef, Cortef], methylprednisolone [Medrol, Solu-Medrol], prednisone) ☐ Cyclosporine (Sandimmune) ☐ Mesalamine (e.g., Apriso, Asacol, Lialda, Pentasa, Canasa, Rowasa) ☐ Mercaptopurine (Purinethol) ☐ Sulfasalazine ☐ Tacrolimus (Prograf) ☐ Metronidazole (Flagyl) or Ciprofloxacin (Cipro) (for pouchitis only)

☐ Yes ☐ No Will the initial (induction) dose of Stelara (ustekinumab) be administered intravenously?
☐ Yes ☐ No Will all doses after the initial dose be administered subcutaneously?

<u>For Continuation of Therapy (clinical documentation required for all requests):</u>

Please indicate length of time on Stelara (ustekinumab): ____________________
☐ Yes ☐ No Is this continuation request a result of the patient receiving samples of Stelara (ustekinumab)?
☐ Yes ☐ No Is there clinical documentation of disease stability or improvement? ☐ disease stability ☐ improvement
☐ Yes ☐ No Does the patient have any risk factors for TB?
→ ☐ Yes ☐ No Has the patient had a TB test within the past year?
→ (check all that apply): ☐ PPD test ☐ interferon-gamma assay (IGRA) ☐ chest x-ray
Please enter the results of the TB test: ☐ positive ☐ negative ☐ unknown

For Crohn's Disease, Plaque Psoriasis, Ulcerative Colitis:
Please indicate the severity of the disease at baseline (pretreatment with Stelara (ustekinumab)): ☐ mild ☐ moderate ☐ severe

For Psoriatic Arthritis:
☐ Yes ☐ No Does the patient have co-existent moderate to severe plaque psoriasis?

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.