aetna®

Stelara® (ustekinumab) Specialty Medication Precertification Request

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

Aetna Precertification Notification
Phone: 1-855-240-0535
FAX: 1-877-269-9916

For Medicare Advantage Part B:
FAX: 1-844-268-7263

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** ☐ **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 ☐ Mail Order
☐ Other: _____
Name: _____
Address: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____

E. PRODUCT INFORMATION

Request is for Stelara *(Check One):* ☐ 45mg ☐ 90mg **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 Stelara be given concomitantly with apremilast, tofacitinib, or other biologic DMARDs (e.g., adalimumab, infliximab)?

☐ Yes ☐ No Does the patient have a documented TB test within 6 months of initiating a biologic therapy?
(check all that apply): ☐ PPD test ☐ interferon-gamma assay (IGRA) ☐ chest x-ray
→ Please enter the date and results of the TB test: Date: ____/____/____ Results: ☐ 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 ustekinumab (Stelara)?

Crohn's Disease

☐ Yes ☐ No Is there evidence that the disease is active?

☐ Yes ☐ No Is the patient symptomatic? Please select which of the symptoms the patient exhibits:
☐ abdominal pain ☐ arthritis ☐ bleeding ☐ diarrhea ☐ internal fistulae ☐ intestinal obstruction
☐ megacolon ☐ perianal disease ☐ spondylitis ☐ weight loss ☐ Other: _____
What is the severity of the patient's Crohn's disease? ☐ Mild ☐ Moderate ☐ Severe

☐ Yes ☐ No Have the symptoms remained active despite treatment with either azathioprine, corticosteroid or 6-mercaptopurine?
→ Please list medication and date range: Name: _____ Date range: ____/____/____ to ____/____/____
Please list medication and date range: Name: _____ Date range: ____/____/____ to ____/____/____
Is this request for subcutaneous or intravenous formulation? ☐ Intravenous ☐ Subcutaneous

☐ Yes ☐ No Will the initial dose be administered intravenously?
(For induction doses contact Specialty Precert at 866-503-0857/ fax: 888-267-3277)

☐ Yes ☐ No Will all doses after the initial dose be administered subcutaneously?

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

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 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? Check all that apply: ☐ Hands ☐ Feet ☐ Face ☐ Genitals

Adult:

☐ Yes ☐ No Is the patient a candidate for systemic therapy?
☐ Yes ☐ No Was the trial with systemic conventional DMARD(s) (e.g., methotrexate, acetretin, or cyclosporine) ineffective?
Provide the name and date range: Name: _____ Date range: ____/____/____ to ____/____/____
☐ Yes ☐ No Was the trial with systemic conventional DMARD(s) not tolerated?
☐ Yes ☐ No Is systemic conventional DMARD(s) contraindicated?
☐ Yes ☐ No Is the patient a candidate for phototherapy?
→ ☐ Yes ☐ No Was the trial with phototherapy ineffective? Please check all that apply:
☐ Psoralens (methoxsalen, trioxsalen) with UVA light (PUVA) ☐ Home UVB
☐ UVB (standard or narrow-band) ☐ UVB with coal tar or dithranol
Date range of phototherapy use: ____/____/____ to ____/____/____
☐ Yes ☐ No Was the trial with phototherapy not tolerated?
☐ Yes ☐ No Is phototherapy contraindicated?
☐ Yes ☐ No Is systemic therapy **and** phototherapy contraindicated?

Pediatric:

☐ Yes ☐ No Is the patient a candidate for phototherapy?
→ ☐ Yes ☐ No Was the trial with phototherapy ineffective? Please check all that apply:
☐ Psoralens (methoxsalen, trioxsalen) with UVA light (PUVA) ☐ Home UVB
☐ UVB (standard or narrow-band) ☐ UVB with coal tar or dithranol
Date range of phototherapy use: ____/____/____ to ____/____/____

Psoriatic Arthritis

☐ Yes ☐ No Does the patient have **axial** psoriatic arthritis?
→ ☐ Yes ☐ No Is there evidence that the disease is active?
☐ Yes ☐ No Does the patient have co-existent moderate to severe plaque psoriasis?
☐ Yes ☐ No Has the patient had an ineffective response to at least **TWO (NSAIDs**)? Provide the names and date ranges:
NSAID #1: _____ Date range: ____/____/____ to ____/____/____
NSAID #2: _____ Date range: ____/____/____ to ____/____/____
☐ Yes ☐ No Does the patient have **non-axial** psoriatic arthritis?
→ ☐ Yes ☐ No Is there evidence that the disease is active?
☐ Yes ☐ No Does the patient have co-existent moderate to severe plaque psoriasis?
☐ Yes ☐ No Was the treatment with methotrexate ineffective? ***If yes***, Date range: ____/____/____ to ____/____/____
☐ Yes ☐ No Was the treatment with methotrexate not tolerated or contraindicated?
☐ Not tolerated ☐ Contraindicated
→ ☐ Yes ☐ No Has the patient had an ineffective response to at least 1 (other than methotrexate) conventional (DMARD)?
Provide the name and date range: Name: _____ Date range: ____/____/____

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

For ALL continuation of therapy requests: (Clinical documentation required for all requests)

☐ Yes ☐ No Has the patient received samples of ustekinumab (Stelara)? (Sampling of Stelara does not guarantee coverage under the provisions of the pharmacy benefit)

☐ 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 12 months?
(check all that apply): ☐ PPD test ☐ interferon-gamma assay (IGRA) ☐ chest x-ray
Please enter the date and results of the TB test: Date: ____/____/____
Results: ☐ 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 ustekinumab (Stelara)?

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.