aetna™

MEDICARE FORM

Stelara® (ustekinumab) Specialty Medication Precertification Request

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

For Medicare Advantage Part B:
PHONE: 1-866-503-0857
FAX: 1-844-268-7263

For other lines of business:
Please use other form.

Note: Stelara is non preferred. Renflexis is preferred for MA plans and Humira is preferred for MAPD plans.

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:
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: _____

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: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____

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. Renflexis is preferred for MA plans and Humira is preferred for MAPD plans.

☐ Yes ☐ No Has the patient had prior therapy with Stelara (ustekinumab) within the last 365 days?
☐ Yes ☐ No Has the patient had a trial, intolerance, or contraindication to Renflexis (infliximab-abda)?
☐ Yes ☐ No Has the patient had a trial, intolerance, or contraindication to Humira (adalimumab)?

Please explain if there are any other medical reason(s) that the patient cannot use Renflexis (infliximab-abda).

_____
_____

Please explain if there are any other medical reason(s) that the patient cannot use Humira (adalimumab).

_____
_____

☐ 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)?

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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.

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:
Please select: ☐ Less than 1 month ☐ 1 month ☐ 2 months ☐ 3 months or greater

☐ 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: _____
Please indicate the length of the medication trial: ☐ Less than 1 month ☐ 1 month ☐ 2 months ☐ 3 months or greater

☐ Yes ☐ No Will the initial (induction) dose of Stelara (ustekinumab) be administered intravenously?
(For induction doses contact Specialty Precert at 866-752-7021/ fax: 888-267-3277)

☐ 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, acetretin, 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: _____
Please indicate the length of the medication trial: ☐ Less than 1 month ☐ 1 month ☐ 2 months ☐ 3 months or greater

☐ 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: _____
Please indicate length of treatment: ☐ Less than 1 month ☐ 1 month ☐ 2 months ☐ 3 months or greater
NSAID #2: _____
Please indicate length of treatment: ☐ Less than 1 month ☐ 1 month ☐ 2 months ☐ 3 months or greater

☐ 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: _____
Please indicate length of trial:
☐ Less than 1 month ☐ 1 month ☐ 2 months ☐ 3 months or greater
→ Indicate length of therapy: ☐ Less than 1 month ☐ 1 month ☐ 2 months ☐ 3 months or greater

For Continuation of Therapy (clinical documentation required for all requests):

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:
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.