



MEDICARE FORM

Stelara® (ustekinumab) Specialty Medication Precertification Request

Page 1 of 3

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

For Medicare Advantage Part B:

FAX: 1-844-268-7263

PHONE: 1-866-503-0857

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 #: _____	Does patient have other coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No
Group #: _____	If yes, provide ID#: _____ Carrier Name: _____
Insured: _____	Insured: _____

C. PRESCRIBER INFORMATION

First Name:		Last Name:		(Check One): <input type="checkbox"/> M.D. <input type="checkbox"/> D.O. <input type="checkbox"/> N.P. <input type="checkbox"/> 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: <input type="checkbox"/> Self-administered <input type="checkbox"/> Physician's Office <input type="checkbox"/> Home <input type="checkbox"/> Outpatient Infusion Center Phone: _____ Center Name: _____ <input type="checkbox"/> Home Infusion Center Phone: _____ Agency Name: _____ <input type="checkbox"/> 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: <input type="checkbox"/> Physician's Office <input type="checkbox"/> Retail Pharmacy <input type="checkbox"/> Specialty Pharmacy <input type="checkbox"/> Mail Order <input type="checkbox"/> Other: _____ Name: _____ Address: _____ City: _____ State: _____ ZIP: _____ Phone: _____ Fax: _____ TIN: _____ PIN: _____ NPI: _____ E. PRODUCT INFORMATION Request is for Stelara (ustekinumab) (Check One): <input type="checkbox"/> 45mg <input type="checkbox"/> 90mg Route: _____ Frequency: _____ HCPCS Code: _____ <input type="checkbox"/> IV <input type="checkbox"/> SC
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F. DIAGNOSIS INFORMATION - Please indicate primary ICD Code and specify 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. Avsola, Entyvio, Remicade, and Simponi Aria are preferred for MA plans. For MAPD plans, Avsola, Entyvio, and Remicade are preferred for ulcerative colitis and Enbrel, Humira, Skyrizi, Otezla, Rinvoq, 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, intolerance, or contraindication to any of the following? (select all that apply)
 Entyvio (vedolizumab) Remicade (infliximab) Avsola (infliximab-axxq) Simponi Aria (golimumab)
 Yes No Has the patient had a trial, 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) Remicade (infliximab) Avsola (infliximab-axxq) 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)

Continued on next page



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Patient First Name	Patient Last Name	Patient Phone	Patient DOB
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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, 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: _____
- 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

Continued on next page



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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?

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, 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.