



Stelara® (ustekinumab) Specialty Medication Precertification Request

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

Aetna Precertification Notification

Phone: 1-855-240-0535

FAX: 1-877-269-9916

IV Formulation only:

Phone: 1-866-752-7021

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

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:	
Provider Email:			Office Contact Name:		Phone:

Specialty (Check one): Dermatologist Gastroenterologist Rheumatologist Other: _____

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:		Dispensing Provider/Pharmacy: Patient Selected choice	
<input type="checkbox"/> Self-administered <input type="checkbox"/> Physician's Office		<input type="checkbox"/> Physician's Office <input type="checkbox"/> Retail Pharmacy	
<input type="checkbox"/> Outpatient Infusion Center Phone: _____		<input type="checkbox"/> Specialty Pharmacy <input type="checkbox"/> Other _____	
Center Name: _____		Name: _____	
<input type="checkbox"/> Home Infusion Center Phone: _____		Address: _____	
Agency Name: _____		Phone: _____ Fax: _____	
<input type="checkbox"/> Administration code(s) (CPT): _____		TIN: _____ PIN: _____	
Address: _____			

E. PRODUCT INFORMATION

Request is for Stelara (ustekinumab) (Check One): 45mg 90mg 130mg/26 ml (5mg/ml) 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 antirheumatic 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 been completed

latent TB and treatment for latent TB has not been initiated

active TB

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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 Crohn's disease (CD)?

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 Has the patient ever received (including current utilizers) Otezla or a biologic (e.g., Humira) 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

Yes No Has the patient been diagnosed with active psoriatic arthritis (PsA)?

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 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 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], metronidazole/ciprofloxacin [for pouchitis only])?

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) Metronidazole (Flagyl) or Ciprofloxacin (Cipro) (for pouchitis only)

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

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?

Please indicate which of the following has the patient experienced improvement in from baseline:

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.