Fax completed form to: (855) 840-1678
If this is an URGENT request, please call (800) 882-4462 (800.88.CIGNA)

Imuldosa, Otulfi, Pyzchiva, Stelara, Ustekinumab, Steqeyma IV

(ustekinumab IV)

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician Name:			*Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed*		
Specialty:	* DEA, NPI or TIN:		* Patient Name:		
Office Contact Person:			* Cigna ID:	* Date of Birth:	
Office Phone:			* Patient Street Address:		
Office Fax:			City:	State:	Zip:
Office Street Address:			Patient Phone:		
City:	State:	Zip:			

Urgency:

☐ Standard ☐ Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)

Medication requested:

☐ Imuldosa 130mg/26ml
☐ Otulfi 130mg/26ml
☐ Pyzchiva 130mg/26ml
☐ Stelara 130mg/26ml
☐ Steqeyma 130mg/26ml
☐ Ustekinumab 130mg/26ml

Dose and Quantity: Duration of therapy: J-Code:

Frequency of administration: ICD10:

What is your patient's current weight? _____kg/lb

Where will this medication be obtained?

☐ Accredo Specialty Pharmacy**
☐ Hospital Outpatient
☐ Retail pharmacy
☐ Other (please specify):
☐ Home Health / Home Infusion vendor
☐ Physician's office stock (billing on a medical claim form)

***Cigna's nationally preferred specialty pharmacy*

*****Medication orders can be placed with Accredo via E-prescribe - Accredo (1620 Century Center Pkwy, Memphis, TN 38134-8822 | NCPDP 4436920), Fax 888.302.1028, or Verbal 866.759.1557*

Facility and/or doctor dispensing and administering medication:

Facility Name: State: Tax ID#:
Address (City, State, Zip Code):

Is the requested medication for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient? ☐ Yes ☐ No

What is the indication or diagnosis?

☐ Ankylosing Spondylitis
☐ Crohn's Disease
☐ Plaque Psoriasis
☐ Psoriatic arthritis
☐ Ulcerative colitis
☐ All other indications

Clinical Information:

Will the requested medication be used in combination with a BIOLOGIC or with a targeted synthetic oral small molecule drug?

☐ Biologic (an adalimumab product [Humira, biosimilar], Bimzelx, Cimzia, Cosentyx (IV or SC), etanercept SC product [Enbrel, biosimilar], Entyvio (IV or SC), Ilumya, infliximab IV products [Remicade, biosimilar], Kevzara, Kineret, Omvoh (IV or SC), Orencia [IV or SC], a rituximab IV product [Rituxan, biosimilar], Skyrizi (IV or SC), Siliq, Simponi [Aria or SC]), Taltz, a tocilizumab product [Actemra (IV or SC), biosimilar], Tremfya (IV or SC), an ustekinumab subcutaneous product [Stelara SC, biosimilar], or Zymfentra.
☐ Targeted synthetic oral small molecule drug (such as Cibinqo, Leqselvi, Litfulo, Sotyktu, Olumiant, Otezla, Otezla XR, Rinvoq, Rinvoq LQ, Xeljanz, Xeljanz XR, Velsipity, or Zeposia.)
☐ Conventional synthetic DMARD (such as methotrexate, leflunomide, sulfasalazine, hydroxychloroquine)
☐ No, the requested medication will NOT be used in combination with another BIOLOGIC or Targeted Synthetic oral small molecule drug

Is documentation being provided to confirm that the patient has tried ALL of Selarsdi, ustekinumab-ttwe, and Yesintek intravenous? (Note: A trial of Pyzchiva counts toward a trial of ustekinumab-ttwe)? PLEASE NOTE: Medical documentation specific to your response must be attached to this case or your request may be denied. Documentation may include, but is not limited to, chart notes, laboratory results, medical test results,claims records, prescription receipts, and/or other information. All documentation must include patient-specific identifying information.
☐ Yes
☐ No - The preferred products are Selarsdi, ustekinumab-ttwe, and Yesintek intravenous. A request for one of these products may be reviewed.

> (if yes) Is documentation being provided confirming that the patient cannot continue to use ALL Preferred medications (that is, Selarsdi, ustekinumab-ttwe, and Yesintek intravenous) due to formulation differences in the inactive ingredient(s) [for example, differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction? PLEASE NOTE: Medical documentation specific to your response must be attached to this case or your request may be denied. Documentation may include, but is not limited to, chart notes, laboratory results, medical test results, claims records, prescription receipts, and/or other information. All documentation must include patient-specific identifying information.
> ☐ Yes
> ☐ No - The preferred products are Selarsdi, ustekinumab-ttwe, and Yesintek intravenous. A request for one of these products may be reviewed.

If Crohn's disease:

Will the requested medication be used as induction therapy? ☐ Yes ☐ No

Is the requested medication prescribed by or in consultation with a gastroenterologist? ☐ Yes ☐ No

Has the patient tried a systemic corticosteroid, or the patient is currently on a systemic corticosteroid, or is a systemic corticosteroid contraindicated in this patient? ☐ Yes ☐ No

Has the patient tried one other conventional systemic therapy for Crohn's disease? Please Note: Examples include: azathioprine, 6-mercaptopurine (6-MP), or methotrexate (MTX). A trial of mesalamine does not count as a systemic agent for Crohn's disease. ☐ Yes ☐ No

Has the patient tried a biologic for Crohn's disease? Please Note: A biosimilar of the requested biologic does not count. Examples of biologics include Cimzia, Entyvio (IV, SC), an adalimumab product (for example, Humira, biosimilars), an infliximab product (for example, Remicade, biosimilars, Zymfentra), Omvoh (SC, IV), Skyrizi (SC, IV), or an ustekinumab subcutaneous product (Stelara SC, biosimilars). ☐ Yes ☐ No

Does the patient have enterocutaneous (perianal or abdominal) or rectovaginal fistulas? ☐ Yes ☐ No

Has the patient had ileocolonic resection (to reduce the chance of Crohn's disease recurrence)? ☐ Yes ☐ No

If Ulcerative colitis:

Will the requested medication be used as induction therapy? ☐ Yes ☐ No

Is the requested medication prescribed by or in consultation with a gastroenterologist? ☐ Yes ☐ No

Additional pertinent information:

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature:_____ **Date:**_____

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