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

Otulfi SC, Pyzchiva SC, Stelara SC, Ustekinumab SC (by Janssen)

(ustekinumab SC)

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:

☐ Otulfi 45 mg/0.5ml vials
☐ Pyzchiva 45 mg/0.5ml vials
☐ Stelara 45 mg/0.5ml vials
☐ Ustekinumab 45 mg/0.5ml vials
☐ Other

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 given in combination with a BIOLOGIC or in combination 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 product [Stelara (IV or 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

If Otulfi SC or Pyzchiva SC is requested:

Is documentation being provided to confirm that the patient has tried ALL of Selarsdi, ustekinumab-ttwe, and Yesintek subcutaneous ? A trial of Pyzchiva counts toward a trial of ustekinumab-ttwe. A trial of ustekinumab-aekn counts towards a trial of Selarsdi. 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

Is documentation being provided confirming that the patient cannot continue to use ALL Preferred medications (that is, Selarsdi, ustekinumab-ttwe, and Yesintek subcutaneous) 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

If Stelara SC or Ustekinumab SC is requested:

Is documentation being provided to confirm that the patient has tried ONE of Selarsdi, ustekinumab-ttwe, or Yesintek subcutaneous? 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

Is documentation being provided confirming that the patient cannot continue to use the Preferred medications (that is, Selarsdi, ustekinumab-ttwe, or Yesintek subcutaneous) 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

For Crohn's Disease:

(if Crohn's) Is the patient currently receiving the requested medication? ☐ Yes ☐ No

(if currently receiving) Has the patient already received at least 6 months of therapy with the requested medication? Please Note: Answer No if the patient has received less than 6 months of therapy or if the patient is restarting therapy with an ustekinumab product. ☐ Yes ☐ No

(if yes) When assessed by at least one objective measure, has the patient experienced a beneficial clinical response from baseline (prior to initiating an ustekinumab product)? Please Note: Examples of objective measures include fecal markers (for example, fecal lactoferrin, fecal calprotectin), serum markers (for example, C-reactive protein), imaging studies (magnetic resonance enterography [MRE], computed tomography enterography [CTE]), endoscopic assessment, and/or reduced dose of corticosteroids. ☐ Yes ☐ No

(if no) Compared with baseline (prior to initiating the requested medication), has the patient experienced an improvement in at least one symptom, such as decreased pain, fatigue, stool frequency, and/or blood in stool? ☐ Yes ☐ No

(if initial therapy) Is the requested medication prescribed by or in consultation with a gastroenterologist? ☐ Yes ☐ No

(if initial therapy) According to the prescriber, will the patient receive a single induction dose with ustekinumab IV within 2 months of initiating therapy with ustekinumab SC? Please Note: If the patient has already received this induction dose with ustekinumab IV prior to starting ustekinumab SC, please answer yes to this question. ☐ Yes ☐ No

(if initial therapy) Has the patient tried corticosteroids, or is the patient currently on corticosteroids, or are corticosteroids contraindicated in this patient? ☐ Yes ☐ No

(if no) Has the patient tried one conventional systemic therapy for Crohn's disease? Please Note: Examples of conventional systemic therapy for Crohn's disease include azathioprine, 6-mercaptopurine, or Methotrexate (MTX). ☐ Yes ☐ No

(if no) Has the patient tried a biologic other than the requested drug? Please Note: A biosimilar of the requested biologic does not count. Examples of biologics include Cimzia, Entyvio (IV or SC), an adalimumab product (for example, Humira, biosimilars), an infliximab product (for example, Remicade, biosimilars), Skyrizi (SC or IV), Omvoh (IV or SC) or Tremfya (IV or SC). ☐ Yes ☐ No

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

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

For Plaque Psoriasis:

Is the patient currently receiving the requested medication? ☐ Yes ☐ No

(if currently receiving) Has the patient already received at least 3 months of therapy with the requested medication? Please Note: Answer No if the patient has received less than 3 months of therapy or if the patient is restarting therapy with an ustekinumab product. ☐ Yes ☐ No

(if PsO, continued therapy) Has the patient experienced a beneficial clinical response, defined as improvement from baseline (prior to initiating an ustekinumab product) in at least one of the following: estimated body surface area, erythema, induration/thickness, and/or scale of areas affected by psoriasis? ☐ Yes ☐ No

(if PsO, continued therapy) Compared with baseline (prior to receiving an ustekinumab product), has the patient experienced an improvement in at least one symptom, such as decreased pain, itching, and/or burning? ☐ Yes ☐ No

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

Has the patient tried at least one traditional systemic agent for psoriasis for at least 3 months, unless intolerant? Please Note: Examples of traditional systemic agents used for psoriasis include methotrexate, cyclosporine, or acitretin. A 3-month trial of psoralen plus ultraviolet A light (PUVA) also counts. ☐ Yes ☐ No

(if no) Has the patient already had a 3-month trial or previous intolerance to at least one biologic (other than the requested medication), Otezla/Otezla XR (apremilast tablets/extended-release tablets), or Sotyktu (deucravacitinib tablets)? Please Note: A biosimilar of the requested biologic does not count. Examples of biologics include Cimzia (certolizumab pegol SC injection), Bimzelx, an adalimumab product (Humira, biosimilars), an etanercept product (Enbrel, biosimilars), an infliximab IV product (Remicade, biosimilars), Cosentyx (secukinumab for SC injection), Ilumya (tildrakizumab SC injection), Siliq (brodalumab SC injection), Skyrizi (risankizumab SC injection), Taltz (ixekizumab for SC injection), or Tremfya (guselkumab SC injection). A patient who has already tried a biologic for psoriasis, Otezla/Otezla XR, or Sotyktu is not required to "step back" and try a traditional systemic agent for psoriasis. ☐ Yes ☐ No

(if no) According to the prescriber, does the patient have a contraindication to methotrexate? ☐ Yes ☐ No

If Psoriatic Arthritis:

Is the patient currently receiving the requested medication? ☐ Yes ☐ No

Has the patient already received at least 6 months of therapy with the requested medication? Please Note: Answer No if the patient has received less than 6 months of therapy or if the patient is restarting therapy with an ustekinumab product. ☐ Yes ☐ No

(if PsA) Is the requested medication being prescribed by or in consultation with a rheumatologist or a dermatologist? ☐ Yes ☐ No

(if continued therapy) When assessed by at least one objective measure, has the patient experienced a beneficial clinical response from baseline (prior to initiating an ustekinumab product)? Please Note: Examples of standardized measures of disease activity include Disease Activity Index for Psoriatic Arthritis (DAPSA), Composite Psoriatic Disease Activity Index (CPDAI), Psoriatic Arthritis Disease Activity Score (PsA DAS), Grace Index, Leeds Enthesitis Score (LEI), Spondyloarthritis Consortium of Canada (SPARCC) enthesitis score, Leeds Dactylitis Instrument Score, Minimal Disease Activity (MDA), Psoriatic Arthritis Impact of Disease (PsAID-12), and/or serum markers (for example, C-reactive protein, erythrocyte sedimentation rate). ☐ Yes ☐ No

(if continued therapy) Compared with baseline (prior to initiating the requested medication), has the patient experienced an improvement in at least one symptom, such as less joint pain, morning stiffness, or fatigue; improved function or activities of daily living; decreased soft tissue swelling in joints or tendon sheaths)? ☐ Yes ☐ No

If Ulcerative Colitis:

Is the patient currently receiving the requested medication? ☐ Yes ☐ No

Has the patient already received at least 6 months of therapy with the requested medication? Please Note: Answer No if the patient has received less than 6 months of therapy or if the patient is restarting therapy with an ustekinumab product. ☐ Yes ☐ No

(if continued therapy) When assessed by at least one objective measure, has the patient experienced a beneficial clinical response from baseline (prior to initiating the requested medication)? Please Note: Examples of assessment for inflammatory response include fecal markers (for example, fecal calprotectin), serum markers (for example, C-reactive protein), endoscopic assessment, and/or reduced dose of corticosteroids. ☐ Yes ☐ No

Compared with baseline (prior to initiating the requested medication), has the patient experienced an improvement in at least one symptom, such as decreased pain, fatigue, stool frequency, and/or decreased rectal bleeding? ☐ Yes ☐ No

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

(if initial) According to the prescriber, will the patient receive a single induction dose with ustekinumab IV within 2 months of initiating therapy with ustekinumab SC? Please Note: If the patient has already received this induction dose with ustekinumab IV prior to starting ustekinumab SC, please answer yes to this question. ☐ 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:**_____

Save Time! Submit Online at: www.covermymeds.com/main/prior-authorization-forms/cigna/ or via SureScripts in your EHR.

Our standard response time for prescription drug coverage requests is 5 business days. If your request is urgent, it is important that you call us to expedite the request. View our Prescription Drug List and Coverage Policies online at cigna.com.

V010126

Address: Cigna Pharmacy Services, PO Box 42005, Phoenix AZ 85080-2005