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

Selarsdi, Yesintek (subcutaneous) 45mg vial

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:				
Office Contact Person:			* Patient Name:		
Office Phone:			* Cigna ID:	* Date of Birth:	
Office Fax:			* Patient Street Address:		
Office Street Address:			City:	State:	Zip:
City:	State:	Zip:	Patient Phone:		

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:
☐ Selarsdi 45mg/0.5ml vial
☐ Yesintek 45mg/0.5ml vial
☐ 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):

Where will this drug be administered?
☐ Patient's Home
☐ Hospital Outpatient
☐ Physician's Office
☐ Other (please specify):

***NOTE:** Per some Cigna plans, infusion of medication MUST occur in the least intensive, medically appropriate setting.*

Is this patient a candidate for re-direction to an alternate setting (such as alternate infusion site, physician's office, home) with assistance of a Specialty Care Options Case Manager? ☐ Yes ☐ No (provide medical necessity rationale):

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 (AS)
☐ Psoriatic arthritis (PsA)
☐ Ulcerative colitis (UC)
☐ Crohn's disease
☐ Plaque psoriasis
☐ other (please specify):

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 intravenous product [Stelara IV, 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 Crohn's disease:

Is the patient currently receiving an ustekinumab product? ☐ Yes ☐ No

(if yes) 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 the requested medication. ☐ Yes ☐ No

(if already received 6 months or more) 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 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 not currently receiving or on less than 6 months) Is the requested medication prescribed by or in consultation with a gastroenterologist? ☐ Yes ☐ No

(if not currently receiving or on less than 6 months) According to the prescriber, will the patient receive a single induction dose with ustekinumab IV within 2 months of initiating therapy with ustekinumab SC? Notes: 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 not currently receiving or on less than 6 months) Has the patient tried corticosteroids, or the patient is 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 (certolizumab pegol SC injection), Entyvio (SC or IV), an adalimumab product (Humira, biosimilars), an infliximab product (Remicade, biosimilars, Zymfentra), Omvoh (SC or IV), Skyrizi (SC or IV), Tremfya (SC or IV), or an ustekinumab intravenous product (Stelara IV, biosimilars). ☐ 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

If Plaque psoriasis:

Is the patient currently receiving an ustekinumab product? ☐ Yes ☐ No

(if yes) 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 the requested medication. ☐ Yes ☐ No

(if not currently receiving or on less than 3 months) Is the requested medication being prescribed by, or in consultation with, a dermatologist? ☐ Yes ☐ No

(if not currently receiving or on less than 3 months) 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 drug), 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), Tremfya (guselkumab SC injection), or an ustekinumab product (Stelara SC or IV, biosimilars). 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 already received 3 or more months) Has the patient experienced a beneficial clinical response, defined as improvement from baseline (prior to initiating the requested medication) 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 already received 3 or more months) Compared with baseline (prior to receiving the requested medication), has the patient experienced an improvement in at least one symptom, such as decreased pain, itching, and/or burning? ☐ Yes ☐ No

If Ulcerative colitis:

Is the patient currently receiving an ustekinumab product? ☐ Yes ☐ No

(if yes) 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 the requested medication. ☐ Yes ☐ No

(if already received 6 or more months) 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

(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 decreased rectal bleeding? ☐ Yes ☐ No

(if not currently receiving or on less than 6 months) Is the requested medication prescribed by or in consultation with a gastroenterologist? ☐ Yes ☐ No

(if not currently receiving or on less than 6 months) According to the prescriber, will the patient receive a single induction dose with ustekinumab intravenous 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 Psoriatic arthritis (PsA):

Is the patient currently receiving an ustekinumab product? ☐ Yes ☐ No

(if yes) 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 the requested medication. ☐ Yes ☐ No

(if not currently receiving or on less than 6 months) Is the requested medication being prescribed by or in consultation with a rheumatologist or a dermatologist? ☐ Yes ☐ No

(if already on 6 or more months) 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 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 no) 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

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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