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

Stelara SQ
(ustekinumab)

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:
☐ Stelara 45mg/0.5ml syringe ☐ Stelara 90mg/ml syringe
☐ Stelara 45mg/0.5ml vial

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

Frequency of administration: ICD10:
What is your patient's current weight? _____kg/lb
Is this a new start or continuation of therapy? If your patient has already begun treatment with drug samples of **Stelara**, please choose "new start of therapy". ☐ new start of therapy ☐ continued therapy

(if continued therapy) Has your patient had a beneficial response to this drug? ☐ Yes ☐ No

(if no) Please provide clinical support for the continued use of Stelara:

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

Diagnosis related to use:

☐ Ankylosing Spondylitis
☐ Psoriatic arthritis (PsA)
☐ Ulcerative colitis (UC)
☐ Crohn's disease (CD, regional enteritis)
☐ Plaque psoriasis (CPP, PsO, psoriasis vulgaris)
☐ other (please specify):

Clinical Information:

Besides the drug being requested, other biologics and tsDMARDs (targeted synthetic disease-modifying antirheumatic drugs) include Actemra, adalimumab (adalimumab-ADAZ, adalimumab-FKJP, Amjevita, Cyltezo, Hadlima, Hulio, Humira, Hyrimoz, Idacio, Yuflyma, Yusimry), Adbry, Cibinqo, Cimzia, Cosentyx, Enbrel, Entyvio, Ilumya, infliximab (Avsola, Inflectra, Remicade, Renflexis), Kevzara, Kineret, Olumiant, Orencia, Otezla, Rinvoq, rituximab (Riabni, Rituxan, Rituxan Hycela, Ruxience, Truxima), Siliq, Simponi Aria, Simponi, Skyrizi, Sotyktu, Taltz, Tremfya, Tysabri, Xeljanz, Zeposia. Which of the following best describes your patient's situation?

☐ The patient is NOT taking any other biologic or tsDMARD at this time, nor will they in the future. The requested drug is the only biologic or tsDMARD the patient is/will be using.
☐ The patient is currently on another biologic or tsDMARD, but this drug will be stopped and the requested drug will be started.
☐ The patient is currently on another biologic or tsDMARD, and the requested drug will be added. The patient may continue to take both drugs together.
☐ The patient is currently on BOTH the requested drug AND another biologic or tsDMARD.
☐ other

(if other/more than the requested drug) Please provide name of drug, dates taken and, if applicable, the clinical rationale for the combined use of the requested drug and another biologic to treat your patient's diagnosis.

If Crohn's Disease (CD, regional enteritis)

Prior to starting therapy with Stelara subcutaneous, has/will the patient receive(d) a single induction dose with Stelara intravenous? ☐ Yes ☐ No

Has the patient already tried a biologic for Crohn's Disease? ☐ Yes ☐ No

Does the patient meet ONE of these?
☐ Severe disease needing hospitalization
☐ Involvement of the UPPER GI tract
☐ Patient is a Smoker
☐ Patient is LESS THAN 40 years of age
☐ Stricturing disease
☐ Perianal disease
☐ Other enterocutaneous fistula
☐ Extraintestinal manifestations (ankylosing spondylitis, pyoderma gangrenosum, erythema nodosum)
☐ Previous Crohn's disease-related surgery (for example, ileocolonic resection (to reduce the chance of Crohn's disease recurrence)
☐ Bowel obstruction
☐ History of abscess or perforation (after healing)
☐ MORE THAN 1 of the above
☐ None of the above

The covered alternative is one corticosteroid, or a corticosteroid will be taken concurrently with Stelara SC. If your patient has tried this drug, please provide drug strength, date(s) taken and for how long, and what the documented results were of taking this drug, including any intolerances or adverse reactions your patient experienced. If your patient has NOT tried this drug, please provide details why your patient can't try this alternative.

Per the information provided above, which of the following is true for your patient in regards to the covered alternative?
☐ The patient tried the alternative, but it didn't work.
☐ The patient will take a corticosteroid concurrently with Stelara SC
☐ The patient tried the alternative, but they did not tolerate it.
☐ The patient cannot try the alternative because of a contraindication to this drug.
☐ Other

The covered alternative is one conventional systemic therapy, or a conventional systemic therapy will be taken concurrently with Stelara SC. If your patient has tried this drug, please provide drug strength, date(s) taken and for how long, and what the documented results were of taking this drug, including any intolerances or adverse reactions your patient experienced. If your patient has NOT tried this drug, please provide details why your patient can't try this alternative.

Per the information provided above, which of the following is true for your patient in regards to the covered alternative?
☐ The patient tried the alternative, but it didn't work.
☐ The patient will take a conventional systemic therapy concurrently with Stelara SC
☐ The patient tried the alternative, but they did not tolerate it.
☐ The patient cannot try the alternative because of a contraindication to this drug.
☐ Other

Is this drug being prescribed by, or in consultation with, a gastroenterologist? ☐ Yes ☐ No

If Plaque Psoriasis (CPP, PsO, psoriasis vulgaris)

Does your patient have ONE of the following?
☐ Affected BSA (body surface area) is greater than 5%
☐ Affected BSA is less than 5% AND the following area(s) are involved: scalp, face, the palms and soles (palmoplantar disease), or genitals
☐ None of the above

Has the patient already tried a biologic or targeted synthetic DMARD (tsDMARD) for Plaque Psoriasis? ☐ Yes ☐ No

The covered alternatives are: A. Topical therapy (for example, topical corticosteroids, topical vitamin D analogs, Tazorac); B. Systemic therapy (for example, methotrexate, cyclosporine, Soriatane); C. Phototherapy. For the alternatives tried, please include drug name and strength, date(s) taken and for how long, and what the documented results were of taking each drug, including any intolerances or adverse reactions your patient experienced. For the alternatives NOT tried, please provide details why your patient can't try that drug.

Per the information provided above, which of the following is true for your patient in regards to the covered alternatives?
☐ The patient tried one of the alternatives, but it didn't work.
☐ The patient tried all of these alternatives, but they did not tolerate any of them.
☐ The patient cannot try any of these alternatives because of a contraindication to each of these drugs.
☐ Other

Is this drug being prescribed by, or in consultation with, a dermatologist? ☐ Yes ☐ No

If Psoriatic arthritis (PsA)

Has your patient already tried a biologic or targeted synthetic DMARD (tsDMARD) for Psoriatic Arthritis? ☐ Yes ☐ No

(if PsA) Does your patient primarily have axial disease -OR- non-axial disease?
☐ Non-axial disease
☐ Axial disease

(if Non-axial disease) The covered alternative is one disease-modifying anti-rheumatic drug (DMARD). If your patient has tried this drug, please provide drug strength, date(s) taken and for how long, and what the documented results were of taking this drug, including any intolerances or adverse reactions your patient experienced. If your patient has NOT tried this drug, please provide details why your patient can't try this alternative.

(if Non-axial disease) Per the information provided above, which of the following is true for your patient in regards to the covered alternative?
☐ The patient tried one DMARD, but it didn't work.
☐ The patient tried ALL DMARDS, but they did not tolerate each one.
☐ The patient cannot try ANY DMARDs because of a contraindication to each of these drugs.
☐ Other

(if axial disease) The covered alternative is one conventional synthetic disease-modifying anti-rheumatic drug (csDMARD), or a nonsteroidal anti-inflammatory drug (NSAID). If your patient has tried this drug, please provide drug strength, date(s) taken and for how long, and what the documented results were of taking this drug, including any intolerances or adverse reactions your patient experienced. If your patient has NOT tried this drug, please provide details why your patient can't try this alternative.

(if axial disease) Per the information provided above, which of the following is true for your patient in regards to the covered alternative?
☐ The patient tried ONE of these alternatives, but it didn't work.
☐ The patient tried ALL csDMARD and NSAIDs, but did not tolerate any of these drugs.
☐ The patient can't try ANY csDMARDs or NSAIDs because of a contraindication to each of these drugs
☐ Other

(if PsA) Is this drug being prescribed by, or in consultation with, a rheumatologist or dermatologist? ☐ Yes ☐ No

If Ulcerative Colitis (UC)

Prior to starting therapy with Stelara subcutaneous, has/will the patient receive(d) a single induction dose with Stelara intravenous? ☐ Yes ☐ No

Has the patient already tried a biologic or targeted synthetic DMARD (tsDMARD) for Ulcerative Colitis? ☐ Yes ☐ No

Does the patient have pouchitis and has tried therapy with an antibiotic (for example, metronidazole, ciprofloxacin), corticosteroid enema or suppository, or mesalamine enema or suppository? ☐ Yes ☐ No

The covered alternative is one conventional systemic therapy (for example, aminosalicylates, corticosteroids, immunosuppressants). If your patient has tried this drug, please provide drug strength, date(s) taken and for how long, and what the documented results were of taking this drug, including any intolerances or adverse reactions your patient experienced. If your patient has NOT tried this drug, please provide details why your patient can't try this alternative.

Per the information provided above, which of the following is true for your patient in regards to the covered alternative?
☐ The patient tried ONE alternative, but it didn't work.
☐ The patient tried ALL conventional systemic therapy, but they did not tolerate each one.
☐ The patient can't try ANY conventional systemic therapy because of a contraindication to each of these drugs.
☐ Other

Is this drug being prescribed by, or in consultation with, a gastroenterologist? ☐ Yes ☐ No

Additional pertinent information: *Please provide clinical rationale for the use of this drug for your patient (pertinent patient history, alternatives tried, any inability to use alternatives above or standard therapy, etc). Please include drug name(s), date(s) taken and for how long, and what the documented results were of taking each drug, including any intolerances or adverse reactions your patient experienced.*

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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