



# MEDICARE FORM

## Stelara® (ustekinumab) Specialty Medication Precertification Request

Page 1 of 3

(Please return Pages 1 to 3 for precertification of medications.)

Virginia (HMO D-SNP)

FAX: 1-833-280-5224

PHONE: 1-855-463-0933

For other lines of business:  
Please use other form.

Note: Stelara is non-preferred.  
Preferred products vary based on indication. See section G below.

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: _____

### 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:

### D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

<b>Place of Administration:</b> <input type="checkbox"/> Self-administered <input type="checkbox"/> Physician's Office <input type="checkbox"/> Home <input type="checkbox"/> Outpatient Infusion Center    Phone: _____ Center Name: _____ <input type="checkbox"/> Home Infusion Center    Phone: _____ Agency Name: _____ <input type="checkbox"/> Administration code(s) (CPT): _____ Address: _____ City: _____ State: _____ ZIP: _____ Phone: _____ Fax: _____ TIN: _____ PIN: _____ NPI: _____ <b>Please explain if there are any medical reason(s) why the patient cannot self-inject the requested drug:</b> _____	<b>Dispensing Provider/Pharmacy:</b> <input type="checkbox"/> Physician's Office <input type="checkbox"/> Retail Pharmacy <input type="checkbox"/> Specialty Pharmacy <input type="checkbox"/> Mail Order <input type="checkbox"/> Other: _____ Name: _____ Address: _____ City: _____ State: _____ ZIP: _____ Phone: _____ Fax: _____ TIN: _____ PIN: _____ NPI: _____
--	---

### E. PRODUCT INFORMATION

Request is for Stelara (ustekinumab) (Check One):

45mg     90mg    Route: \_\_\_\_\_

Frequency: \_\_\_\_\_

HCPCS Code: \_\_\_\_\_     IV     SC

### 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 Initiation Requests (clinical documentation required for all requests):**  
**Note: Stelara is non-preferred. Entyvio, Inflectra, Remicade, and Simponi Aria are preferred for MA plans. For MAPD plans, Entyvio, Inflectra, and Remicade are preferred for ulcerative colitis and Enbrel, Humira, Otezla, Rinvoq, Skyrizi, and Xeljanz/Xeljanz XR are preferred for other indications. Preferred products vary based on indication.**

Yes     No    Has the patient had prior therapy with Stelara (ustekinumab) within the last 365 days?  
 Yes     No    Has the patient had a trial and failure, intolerance, or contraindication to any of the following? (select all that apply)  
 Entyvio (vedolizumab)     Inflectra (infliximab-dyyb)     Remicade (infliximab)     Simponi Aria (golimumab)  
 Yes     No    Has the patient had a trial and failure, intolerance, or contraindication to any of the following? (select all that apply)  
 Enbrel (etanercept)     Humira (adalimumab)     Otezla (apremilast)     Rinvoq (upadacitinib)     Skyrizi (risankizumab-rzaa)  
 Xeljanz/Xeljanz XR (tofacitinib)

Please explain if there are any other medical reason(s) that the patient cannot use any of the following preferred products when indicated for the patient's diagnosis (select all that apply)  
 Entyvio (vedolizumab)     Inflectra (infliximab-dyyb)     Remicade (infliximab)     Simponi Aria (golimumab)

Please explain if there are any other medical reason(s) that the patient cannot use any of the following preferred products when indicated for the patient's diagnosis (select all that apply)  
 Enbrel (etanercept)     Humira (adalimumab)     Otezla (apremilast)     Rinvoq (upadacitinib)     Skyrizi (risankizumab-rzaa)  
 Xeljanz/Xeljanz XR (tofacitinib)

Continued on next page



# MEDICARE FORM

## Stelara® (ustekinumab) Specialty Medication Precertification Request

Page 2 of 3

(Please return Pages 1 to 3 for precertification of medications.)

Virginia (HMO D-SNP)

FAX: 1-833-280-5224

PHONE: 1-855-463-0933

For other lines of business:  
Please use other form.

Note: Stelara is non-preferred.  
Preferred products vary based  
on indication. See section G.

Patient First Name	Patient Last Name	Patient Phone	Patient DOB
--------------------	-------------------	---------------	-------------

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

- Yes  No Will Stelara (ustekinumab) be given concomitantly with apremilast, tofacitinib, or other biologic DMARDs (e.g., adalimumab, infliximab)?
- Yes  No Has the patient been tested for TB with a PPD test, interferon-release assay (IGRAs) or chest x-ray within 6 months of initiation a biologic therapy?
- (check all that apply):  PPD test  interferon-gamma assay (IGRA)  chest x-ray
- Please enter results of the TB test:  positive  negative  unknown
- If positive, does the patient have latent or active TB?**  latent  active
- If latent TB,  Yes  No Will TB treatment be started before initiation of therapy with Stelara (ustekinumab)?**

#### Crohn's Disease

- Yes  No Does the patient have a diagnosis of fistulizing Crohn's disease?
- Please indicate how long the patient has been diagnosed with fistulizing Crohn's disease:
- Yes  No Does the patient have a diagnosis of Crohn's disease?
- Please indicate the severity of the patient's disease:  mild  moderate  severe
- Yes  No Does the patient have a documented diagnosis of active Crohn's disease?
- Please select all signs/symptoms that apply:
- abdominal pain  arthritis  bleeding  diarrhea  internal fistulae  intestinal obstruction
- megacolon  perianal disease  spondylitis  weight loss  None of the above
- Yes  No Have the Crohn's disease symptoms remained active despite treatment with 6-mercaptopurine, azathioprine, or corticosteroids?
- Please check all medications that apply:  6-mercaptopurine  azathioprine
- corticosteroids- please identify:  prednisone  hydrocortisone  methylprednisolone  Other: \_\_\_\_\_
- Yes  No Will the initial (induction) dose of Stelara (ustekinumab) be administered intravenously?
- Yes  No Will all doses after the initial dose be administered subcutaneously?

#### Plaque Psoriasis (Adult and Pediatric)

- Yes  No Is there clinical documentation of chronic disease?
- Please indicate the severity of the patient's plaque psoriasis:  mild  moderate  severe
- Yes  No Is there evidence that the disease is active?
- Yes  No Is the patient a candidate for systemic therapy or phototherapy?
- Please select:  phototherapy  systemic therapy  phototherapy and systemic therapy
- Please provide the patient's Psoriasis Area and Severity Index (PASI) score: \_\_\_\_\_
- Please indicate the percentage of body surface area affected by plaque psoriasis: \_\_\_\_\_%
- Yes  No Does the plaque psoriasis affect sensitive areas? **If yes**, please select:  hands  feet  face  genitals

#### Adult

- Yes  No Was a trial of systemic conventional DMARD(s) (e.g., methotrexate, acetretin, or cyclosporine) ineffective?
- Yes  No Was the trial with systemic conventional DMARD(s) not tolerated?
- Yes  No Are systemic conventional DMARD(s) contraindicated?
- Please select:  acetretin  cyclosporine  methotrexate  mycophenolate  Other, please explain: \_\_\_\_\_
- Yes  No Was a trial with phototherapy ineffective?
- Yes  No Was the trial with phototherapy not tolerated?
- Yes  No Is phototherapy contraindicated?
- Please check all that apply:  Psoralens (methoxsalen, trioxsalen) with UVA light (PUVA)
- UVB with coal tar or dithranol
- UVB (standard or narrow band)
- Home UVB
- None of the above
- Please indicate the length of trial:  Less than 1 month  1 month  2 months  3 months or greater

#### Pediatric

- Yes  No Was a trial with phototherapy ineffective, not tolerated, or contraindicated?
- Please check all that apply:  Psoralens (methoxsalen, trioxsalen) with UVA light (PUVA)
- UVB with coal tar or dithranol
- UVB (standard or narrow band)
- Home UVB
- None of the above
- Please indicate the length of trial:  Less than 1 month  1 month  2 months  3 months or greater

Continued on next page



# MEDICARE FORM

## Stelara® (ustekinumab) Specialty Medication Precertification Request

Page 3 of 3

(Please return Pages 1 to 3 for precertification of medications.)

Virginia (HMO D-SNP)

FAX: 1-833-280-5224

PHONE: 1-855-463-0933

For other lines of business:  
Please use other form.

Note: Stelara is non-preferred.  
Preferred products vary based on indication. See section G.

Patient First Name	Patient Last Name	Patient Phone	Patient DOB
--------------------	-------------------	---------------	-------------

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

#### Psoriatic Arthritis

Yes  No Does the patient have co-existent moderate to severe plaque psoriasis?

Yes  No Is there evidence that the disease is active?

Yes  No Does the patient have **axial** psoriatic arthritis?

→  Yes  No Was the treatment with 2 or more non-steroidal anti-inflammatory drugs (NSAIDs) ineffective?

→ Please provide the names and length of treatment:  
NSAID #1: \_\_\_\_\_  
NSAID #2: \_\_\_\_\_

Yes  No Does the patient have **non-axial** psoriatic arthritis?

→  Yes  No Does the patient have severe disease at presentation, defined as severe disability at onset with erosive disease involving multiple joints?

→  Yes  No Was the treatment with methotrexate ineffective?

→  Yes  No Was treatment with methotrexate not tolerated or contraindicated?

→ Please select:  not tolerated  contraindicated

→  Yes  No Was treatment with another conventional DMARD ineffective?

→ Please select:  cyclophosphamide  cyclosporine  
 hydroxychloroquine  leflunomide  
 sulfasalazine  Other, please explain: \_\_\_\_\_

#### Ulcerative Colitis

Yes  No Has the patient been diagnosed with moderately to severely active ulcerative colitis (UC)?

→  Yes  No Has the patient previously received a biologic 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., budesonide, hydrocortisone [Entocort, Uceris], methylprednisolone, prednisone, cyclosporine [Sandimmune], mesalamine [Asacol, Lialda, Pentasa, Canasa, Rowasa], mercaptopurine [Purinethol], sulfasalazine, tacrolimus [Prograf], metronidazole/ciprofloxacin [for pouchitis only])?

→ Please select:  Azathioprine [Azasan, Imuran]  Corticosteroid (e.g., budesonide [Entocort, Uceris], hydrocortisone [Cortifoam, Colocort, Solu-Cortef, Cortef], methylprednisolone [Medrol, Solu-Medrol], prednisone)  Cyclosporine (Sandimmune)  Mesalamine (e.g., Apriso, Asacol, Lialda, Pentasa, Canasa, Rowasa)  Mercaptopurine (Purinethol)  Sulfasalazine  Tacrolimus (Prograf)  Metronidazole (Flagyl) or Ciprofloxacin (Cipro) (for pouchitis only)

Yes  No Will the initial (induction) dose of Stelara (ustekinumab) be administered intravenously?

Yes  No Will all doses after the initial dose be administered subcutaneously?

#### For Continuation of Therapy (clinical documentation required for all requests):

Please indicate length of time on Stelara (ustekinumab): \_\_\_\_\_

Yes  No Is this continuation request a result of the patient receiving samples of Stelara (ustekinumab)?

Yes  No Is there clinical documentation of disease stability or improvement?  disease stability  improvement

Yes  No Does the patient have any risk factors for TB?

→  Yes  No Has the patient had a TB test within the past year?

→ (check all that apply):  PPD test  interferon-gamma assay (IGRA)  chest x-ray  
Please enter the results of the TB test:  positive  negative  unknown

#### For Crohn's Disease, Plaque Psoriasis, Ulcerative Colitis:

Please indicate the severity of the disease at baseline (pretreatment with Stelara (ustekinumab)):  mild  moderate  severe

#### For Psoriatic Arthritis:

Yes  No Does the patient have co-existent moderate to severe plaque psoriasis?

### 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.