MEDICARE FORM
Stelara® (ustekinumab) Specialty Medication Precertification Request

(All fields must be completed and legible for precertification review.)

For Medicare Advantage Part B:
For other lines of business:
Please use commercial form.

Note: Stelara is preferred for MAPD plans.

Would you like to use electronic prior authorization? Consider using **Availity**, our electronic prior authorization portal. Learn more about **Availity** from the links in the table below.

For phone or fax requests, refer to the table below for routing information. To determine which box to use, refer to the patient's Aetna ID card. State specific special needs and Medicare-Medicaid Plans may be designated on the front of the ID card or in the website URL on the back of the card. If you don't see your specific plan listed, call the number on the back of the member's ID card to confirm routing information.

For **Aetna Medicare Advantage** and **Allina Health Aetna Medicare** members send request to:
Phone: 1-866-503-0857 **(TTY:** 711**)**
Fax: 1-844-268-7263
Availity: https://www.aetna.com/health-care-professionals/resource-center/availity.html

For Aetna Medicare Advantage **Virginia Dual Eligible Special Needs Plans** (HMO D-SNP) send request to:
Phone: 1-855-463-0933
Fax: 1-833-280-5224
Availity: https://www.aetnabetterhealth.com/virginia-hmosnp/providers/portal

For Aetna Assure Premier Plus Medicare Advantage **New Jersey Dual Eligible Special Needs Plans** (HMO D-SNP) send request to:
Phone: 1-844-362-0934
Fax: 1-833-322-0034
Availity: https://www.aetnabetterhealth.com/new-jersey-hmosnp/providers/portal.html

For Aetna Better Health of **Illinois Premier Medicare Medicaid Plan** (MMP) send request to:
Phone: 1-866-600-2139
FAX: 1-855-320-8445
Availity: https://www.aetnabetterhealth.com/illinois/providers/portal

For Aetna Better Health of **Ohio Premier Medicare Medicaid Plan** (MMP) send request to:
Phone: 1-855-364-0974
Fax: 1-855-734-9389
Availity: https://www.aetnabetterhealth.com/ohio/providers/portal

For Aetna Better Health of **Michigan Premier Medicare Medicaid Plan** (MMP) send request to:
Phone: 1-855-676-5772
Fax: 1-844-241-2495
Availity: https://www.aetnabetterhealth.com/michigan/providers/portal.html

MEDICARE FORM
Stelara® (ustekinumab) Specialty Medication Precertification Request

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

For Medicare Advantage Part B:
For other lines of business:
Please use commercial form.

Note: Stelara is preferred for MAPD plans.

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 #: _____
Group #: _____
Insured: _____

Does patient have other coverage? ☐ Yes ☐ No
If yes, provide ID#: _____ Carrier Name: _____
Insured: _____

C. PRESCRIBER INFORMATION

First Name:	Last Name:		*(Check One):* ☐ M.D. ☐ D.O. ☐ N.P. ☐ P.A.		
Address:		City:	State:	ZIP:	
Phone:	Fax:	St Lic #:	NPI #:	DEA #:	UPIN:
Provider Email:	Office Contact Name:		Phone:		

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:

☐ Self-administered ☐ Physician's Office ☐ Home
☐ Outpatient Infusion Center Phone: _____
Center Name: _____
☐ Home Infusion Center Phone: _____
Agency Name: _____
☐ Administration code(s) (CPT): _____
Address: _____
City: _____ State: _____ ZIP: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____
NPI: _____

Please explain if there are any medical reason(s) why the patient cannot self-inject the requested drug:

_____

Dispensing Provider/Pharmacy:

☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Mail Order ☐ 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):

☐ 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)?**

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB

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

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

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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.