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

Stelara IV
(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 130mg/26ml

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 good response to therapy with this drug (such as improvement or remission)?
☐ Yes ☐ No
(if no) Please provide clinical support for the continued use of **Stelara**:

Which applies to your patient?
☐ patient is established on this drug with previous approval by Cigna
☐ patient is established on this drug with previous approval by another health plan
☐ patient is established on this drug with regular use for more than 1 year
☐ patient was previously established on this drug, and is restarting after a break in therapy
Please provide the dates your patient has received **Stelara**:

Besides the drug being requested, other biological drugs include Actemra, Cimzia, Cosentyx, Enbrel, Entyvio, Humira, Ilumya, Inflectra, Kevzara, Kineret, Olumiant, Orencia, Otezla, Remicade, Renflexis, Rinvoq, Rituxan, Siliq, Simponi/Simponi Aria, Skyrizi, Taltz, Tremfya, Tysabri, and Xeljanz/Xeljanz XR. Which of the following best describes your patient's situation?
☐ The patient is NOT taking any other biological at this time, nor will they in the future. The requested drug is the only biological the patient is/will be using.
☐ The patient is currently on another biological, but this drug will be stopped and the requested drug will be started.
☐ The patient is currently on another biological, 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 biological.
☐ other/unknown
(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.

Where will this medication be obtained?
☐ Accredo Specialty Pharmacy**
☐ Prescriber's office stock (billing on a medical claim form)
☐ Other (please specify):
☐ Retail pharmacy
☐ Home Health / Home Infusion vendor
***Cigna's nationally preferred specialty pharmacy*

*****Medication orders can be placed with Accredo via E-prescribe - Accredo (1640 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):

NOTE: *Per some Cigna plans, infusion of medication MUST occur in the lowest cost, medically appropriate setting*
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Is this infusion occurring in a facility affiliated with hospital outpatient setting? ☐ Yes ☐ No

If yes- Is this patient a candidate for re-direction to an alternate setting after 1-2 infusions (such as AIS, MDO, home) with assistance of a Specialty Care Option 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:
☐ moderate to severe Crohn's disease (CD) ☐ moderate to severe Ulcerative colitis (UC)
☐ other (please specify):

Clinical Information:

(if Crohn's) Is this drug being prescribed by, or in consultation with, a gastroenterologist or a prescriber who specializes in Crohn's disease? ☐ Yes ☐ No
(if UC) Is this drug being prescribed by, or in consultation with, a gastroenterologist or a prescriber who specializes in ulcerative colitis? ☐ Yes ☐ No
(if UC) Has the patient already received a biologic for their condition? ☐ Yes ☐ No
(if UC) Did your patient try one conventional therapy (for example, aminosalicylate, corticosteroids or immunosuppressants), but it either did not work well enough OR caused a significant intolerance? ☐ Yes ☐ No
(if no) Is your patient able to try the alternative, one conventional therapy? ☐ Yes ☐ No
(if no) What is the reason your patient can not try the alternative, one conventional therapy?
☐ Patient has at least one contraindication or warning as listed in the alternative drug's prescribing information.
☐ Patient is unable to take the alternative and requires the dosage formulation of the requested drug.
☐ Patient is not a candidate for the alternative due to a disease characteristic, individual clinical factor[s], or other attribute/condition.
☐ other
Please provide specifics to support this reason. _____

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

IFP PLANS ONLY:

(if UC) Has your patient tried Humira and had documented inadequate response or significant intolerance to it? ☐ Yes ☐ No
(if no) Does your patient have documented contraindication per FDA label to Humira? ☐ 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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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.

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