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

Stelara IV, Selarsdi IV, Ustekinumab IV, Ustekinumab-ttwe IV, Yesintek IV

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
☐ Selarsdi 130mg/26ml
☐ Ustekinumab intravenous infusion 130mg/26ml
☐ Ustekinumab-ttwe intravenous infusion 130mg/26ml
☐ Yesintek 130mg/26ml

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):

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
☐ Crohn's Disease
☐ Plaque Psoriasis
☐ Psoriatic arthritis
☐ Ulcerative colitis
☐ other (please specify):

Clinical Information:

Will the requested medication be used in combination with a BIOLOGIC or 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 subcutaneous product [Stelara SC, biosimilar], or Zymfentra.
☐ Targeted synthetic oral small molecule drug (such as Cibinqo, Leqselvi, Litfulo, Sotyktu, Olumiant, Otezla, 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:

Will the requested medication be used as induction therapy? ☐ Yes ☐ No

Is the requested medication prescribed by or in consultation with a gastroenterologist? ☐ Yes ☐ No

Has the patient tried a systemic corticosteroid, or the patient is currently on a systemic corticosteroid, or is a systemic corticosteroid contraindicated in this patient? ☐ Yes ☐ No

Has the patient tried one other conventional systemic therapy for Crohn's disease? Please Note: Examples include: azathioprine, 6-mercaptopurine (6-MP), or methotrexate (MTX). A trial of mesalamine does not count as a systemic agent for Crohn's disease. ☐ Yes ☐ No

Has the patient tried a biologic for Crohn's disease? Please Note: A biosimilar of the requested biologic does not count. Examples of biologics include Cimzia, Entyvio (IV, SC), an adalimumab product (for example, Humira, biosimilars), an infliximab product (for example, Remicade, biosimilars, Zymfentra), Omvoh (SC, IV), Skyrizi (SC, IV), or an ustekinumab subcutaneous product (Stelara SC, biosimilars). ☐ Yes ☐ No

Does the patient have enterocutaneous (perianal or abdominal) or rectovaginal fistulas? ☐ Yes ☐ No

Has the patient had ileocolonic resection (to reduce the chance of Crohn's disease recurrence)? ☐ Yes ☐ No

If Ulcerative colitis:

Will the requested medication be used as induction therapy? ☐ Yes ☐ No

Is the requested medication prescribed by or in consultation with a gastroenterologist? ☐ 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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