



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

Otulf, Pyszchiva, Stelara, Ustekinumab, Starjemza, Steqeyma, Wezlana IV (ustekinumab 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:
City:	State:	Zip:	Patient Phone:		
Urgency: <input type="checkbox"/> Standard <input type="checkbox"/> 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: <input type="checkbox"/> Otulf 130mg/26ml <input type="checkbox"/> Pyszchiva 130mg/26ml <input type="checkbox"/> Stelara 130mg/26ml <input type="checkbox"/> Starjemza 130mg/26ml <input type="checkbox"/> Steqeyma 130mg/26ml <input type="checkbox"/> Ustekinumab 130mg/26ml <input type="checkbox"/> Wezlana 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? <input type="checkbox"/> Accredo Specialty Pharmacy** <input type="checkbox"/> Home Health / Home Infusion vendor <input type="checkbox"/> Hospital Outpatient <input type="checkbox"/> Physician's office stock (billing on a medical claim form) <input type="checkbox"/> Retail pharmacy **Cigna's nationally preferred specialty pharmacy <input type="checkbox"/> Other (please specify): _____					
<i>**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</i>					
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? <input type="checkbox"/> Yes <input type="checkbox"/> No					
What is the indication or diagnosis? <input type="checkbox"/> Ankylosing Spondylitis <input type="checkbox"/> Crohn's Disease <input type="checkbox"/> Plaque Psoriasis <input type="checkbox"/> Psoriatic arthritis <input type="checkbox"/> Ulcerative colitis <input type="checkbox"/> All other indications					

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, Otezla XR, 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 request is for Otulfi, Pyzchiva, Starjemza, Stelara/ustekinumab or Steqeyma) Is documentation being provided to confirm that the patient has tried ALL of Imuldosa (NDCs starting with 69448), Selarsdi, and Yesintek intravenous? (Note: A trial of Imuldosa (NDCs starting with 51407) also counts). PLEASE NOTE: Medical documentation specific to your response must be attached to this case or your request may be denied. Documentation may include, but is not limited to, chart notes, laboratory results, medical test results, claims records, prescription receipts, and/or other information. All documentation must include patient-specific identifying information.

- Yes
- No - The preferred products are Imuldosa (NDCs starting with 69448), Selarsdi, and Yesintek intravenous. A request for one of these products may be reviewed.

(if yes) Is documentation being provided confirming that the patient cannot continue to use ALL Preferred medications (that is, Imuldosa [NDCs starting with 69448], Selarsdi, and Yesintek intravenous) due to formulation differences in the inactive ingredient(s) [for example, differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction? PLEASE NOTE: Medical documentation specific to your response must be attached to this case or your request may be denied. Documentation may include, but is not limited to, chart notes, laboratory results, medical test results, claims records, prescription receipts, and/or other information. All documentation must include patient-specific identifying information.

- Yes
- No - The preferred products are Imuldosa (NDCs starting with 69448), Selarsdi, and Yesintek intravenous. A request for one of these products may be reviewed.

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

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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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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