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

Aetna Precertification Notification Phone: <u>1-866-752-7021</u> (TTY: <u>711</u>)

FAX: <u>1-888-267-3277</u>

For Medicare Advantage Part B: Please Use Medicare Request Form

Please indicate:					/ treatment	/	1						
Precertification Red					_			ne:		Fax	x:		
A. PATIENT INFORM	IATION												
First Name:						Last N	Name:						
Address:						City:				State:		ZIP:	
Home Phone:		Work Phone	e:		Cell Phone:			DOB:		E-mail:		•	
Current Weight:	lbs_or_	kgs	Height:	inc	hes or	cms	Allergies	:					
B. INSURANCE INFO	RMATION												
Aetna Member ID #:				Does	patient have	other c	overage?	☐ Yes	☐ No				
Group #:				If yes	, provide ID#	<u> </u>	_	Carrier	Name: _				
Insured:				Insur	ed:								
Medicare: Yes	☐ No If y	yes, provide	ID #:	•		Medic	caid: 🗌 Ye	s 🗌 No	If yes, p	rovide ID #	<b>#</b> :		
C. PRESCRIBER INF	ORMATIO	N											
First Name:				Last	Name:			(0	Check On	e): 🗌 M.D	). 🔲 D.C	D. 🔲 N.P.	☐ P.A.
Address:						Ci	ity:			State:		ZIP:	
Phone:	I	Fax:		St Lic	<b>;</b> #:	N	PI #:		DEA #:		UPII	N:	
Provider E-mail:				Office	e Contact Nar	ne:				Pho	one:		
Specialty (Check on	e): 🔲 <b>D</b> e	ermatologis	t 🔲 Gastro	enter	ologist 🗌 R	heuma	tologist [	Other: _					
D. DISPENSING PRO	OVIDER/AD	MINISTRAT	ION INFORM	IATION									
Place of Administra	tion:						Dispensing	g Provide	r/Pharma	cy: Patien	t Select	ed choice	
☐ Self-administered	ı [	☐ Physician	's Office				☐ Physicia	_		_			
☐ Outpatient Infusion							☐ Specialty Pharmacy ☐ Other						
Center Nam							Name:						
☐ Home Infusion Co							Address: _						
Agency Nan							Phone:						
Administration co	de(s) (CP	1):					TIN:						
E. PRODUCT INFOR	MATION												
Request is for: Infle		ximab-dvvb	) Dose:				Frequency	:					
F. DIAGNOSIS INFO													
Primary ICD Code:													
G. CLINICAL INFORI													
For All Requests (clir					·				·				
Yes No Will the requested drug be used in combination with any other biologic (e.g., Humira) or targeted synthetic drug (e.g., Olumiant, Otezla, Xeljanz)? Has the patient ever received (including current utilizers) a biologic (e.g., Humira) or targeted synthetic drug (e.g., Olumiant, Xeljanz) associated with an increased risk of tuberculosis (TB)?  Yes No Has the patient had a tuberculosis (TB) test (e.g., tuberculosis skin test [PPD], interferon-release assay [IGRA], chest x-ray) within 6 months of initiating therapy?  (Check all that apply): PPD test interferon-release assay (IGRA) chest x-ray													
					berculosis (TB applies to the			_l negative	∐ unkn	own			
					ent TB has be	•							
☐ latent TB and treatment for latent TB has been completed													
				nt for lat	tent TB has no	t been i	nitiated						
		active TB											



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For Medicare Advantage Part B: Please Use Medicare Request Form

Collinical Information must be completed in its mitted; to all precentification requests.	Patient First Name	Patient Last Name	Patient Phone	Patient DOB			
Ves   No   Is this influsion request in an outpatient hospital setting?   Ves   No   Is the patient represented an adverse event with the requested product that has not responded to conventional interventions (e.g., acetaminophen, steroids, diphenhydramine, fluids, other pre-medications or slowing of influsion rate) or a severe adverse event (napohydrax) anaphydractor reactions, mycoardial inflaration, thromboembolism, or seizures) during or immediately after an influsion?   Ves   No   Does the patient have severe venous access issues that require the use of special interventions only available in the label of the patient have severe venous access issues that require the use of special interventions only available in the label of the patient have severe venous access issues that require the use of special interventions only available in the label of the patient of the patient does not have access to a caregiver?   Ves   No   Does the patient have significant behavioral issues or impairment:   Petition of the patient of the patient of the native and the patient of the patient medically unstable which may include respiratory, cardiovascular, or renal conditions that may limit the patient shalling to the care patients and the patient of the patient of the patient of the patient of the care patients and the patie	G. CLINICAL INFORMATION	N (continued) – Required clinical information r	nust be completed in its entirety for a	Ill precertification requests.			
Ves   No   No   Has the patient experienced an adverse event with the requested product that has not responded to conventional interventions (e.g., ocataminophen, storoids, diphenhydramine, fluids, other pre-medications or slowing of infusion rate) or a severe adverse event (nanphylaxis, anaphylactoid reactions, myocardial infarction, thromboembolism, or seizures) during or immediately after an infusion?				processinoanion requeste:			
vs   No   Mas the patient developed antibodies to inflixinab which increases the risk for inflixion related reactions?		No Has the patient experienced an adverse exinterventions (e.g., acetaminophen, steroid severe adverse event (anaphylaxis, anaphylaxis)	ds, diphenhydramine, fluids, other pre	e-medications or slowing of infusion rate) or			
vs   No   Does the patient have severe venous access issues that require the use of special interventions only available in the outpatient hospital setting?   vs   No   Does the patient thave significant behavioral issues and/or physical or cognitive impairment that would impact the safety of the infusion therapy AND the patient does not have access to a caregiver?   Please provide a description of the behavioral issues or impairment:   vs   No   Intervention   Please provide a description of the behavioral issues or impairment:   vs   No   Intervention   No   No   No   No   No   No   No	□ Yes □	•	fliximah which increases the risk for i	nfusion related reactions?			
vs   No   Does the patient have significant behavioral issues and/or physical or cognitive impairment that would impact the safety of the infusion therapy AND the patient does not have access to a caregiver?   vs   No   Does the patient have significant behavioral issue or impairment:   vs   vs   vs   vs   vs   vs   vs   v							
Yes   No   Does the patient have significant behavioral issues and/or physical or cognitive impairment that would impact the safety of the infusion threapy AND the patient does not have access to a caregiver?   Please provide a description of the behavioral issue or impairment:   please provide a description of the behavioral issue or impairment:   patients ability to tolerate a large volume or load or predispose the patient to a severe adverse event that cannot be managed man atternate setting without appropriate medical personnel and equipment?   Please provide a description of the condition:   Cardiopulmonary:   patients ability to tolerate a large volume or load or predispose the patient to a severe adverse event that cannot be managed man atternate setting without appropriate medical personnel and equipment?   Please provide a description of the condition:   Cardiopulmonary:   Please provide a description of the condition:   Cardiopulmonary:   Please select.   Supported by the manufacturer's prescribing information or dosing guidelines found in the compendia or current iterativent (paydiomes)?   Please select.   Supported by the manufacturer's prescribing information or course the properties of the properties			oo loodoo that require the doe of ope	olar interventions only available in the			
the infusion therapy AND the patient does not have access to a caregiver?    Please provide a description of the behavior alissue or impairment;   Is the patient medically unstable which may include respiratory, cardiovascular, or renal conditions that may limit the patient to a severe adverse event that cannot be managed in an alternate setting without appropriate medical personnel and equipment?   Please provide a description of the condition:   Cardioplumonary:   Cardioplumonary:	☐ Yes ☐		al issues and/or physical or cognitive	impairment that would impact the safety of	:		
Ves   No   Is the patient medically unstable which may include respiratory, cardiovascular, or renal conditions that may limit the patient is a selver volume or load or predispose the patient to a severe adverse event that cannot be managed in an alternate setting without appropriate medical personnel and equipment?   Respiratory:	T T			,			
patient's ability to tolerate a large volume or load or predispose the patient to a severe adverse event that cannot be managed in an alternate setting without appropriate medical personnel and equipment?    Renal:							
managed in an alternate setting without appropriate medical personnel and equipment?    Respiratory:   Respiratory:   Cardiopulmonary:   Cardiopul	☐ Yes ☐						
Please provide a description of the condition:   Cardiopulmonary:   Renal:   Cardiopulmonary:   Cardiopul							
Renal:							
Renal:   Other:   O		Please provide a description of the condition	on: 🔲 Cardiopulmonary:				
Por Initiation Requests (clinical documentation required for all requests):			☐ Respiratory:				
For Initiation Requests (clinical documentation required for all requests):   Yes   No   Is the medication requested for initiation of treatment at a higher dose or frequency of administration (e.g., loading dose)?   Yes   No   Is the requested quantity supported by the manufacturer's prescribing information or dosing guidelines found in the compendia or current literature (e.g., Micromedex DrugDex, NCCN compendia, current treatment guidelines)?   Please select   Supported by the manufacturer's prescribing information or the patient's diagnosis?   Yes   No   Is the requested dose and frequency supported by the manufacturer's prescribing information for the patient's diagnosis?   Yes   No   Is the requested quantity supported by dosing guidelines found in the compendia or current literature (e.g., Micromedex DrugDex, NCCN compendia, current treatment guidelines)?   Yes   No   Is the requested drug being prescribed by or in consultation with an oncologist or hematologist?   Is the requested drug being prescribed by or in consultation with an oncologist or hematologist?   Yes   No   Has the patient experienced an inadequate response to systemic corticosteroids?   Ankylosing spondylitis and Non-radiographic axial spondyloarthritis   Please indicate loading dose at weeks 0, 2 and 6: Please indicate maintenance dose:   frequency:   weeks   Please select which of the following applies to the patient:   Active ankylosing spondylitis (AS)   Active non-radiographic axial spondyloarthritis   No   Is the requested drug being prescribed by or in consultation with a rheumatologist?   No   Has the patient ever received or is currently receiving a biologic (e.g., Humira) indicated for active ankylosing spondylitis and spondyloarthritis?   Yes   No   No   Has the patient ever received or is currently receiving of Dezia or a biologic (e.g., Humira) indicated for the treatment of Behçet's disease   Yes   No   No   No   No   No   No   No   N			☐ Renal:				
Yes   No   Is the medication requested for initiation of treatment at a higher dose or frequency of administration (e.g., loading dose)?   Yes   No   Is the requested quantity supported by the manufacturer's prescribing information or dosing guidelines found in the compendia or current literature (e.g., Micromedex DrugDex, NCCN compendia, current treatment guidelines)?   Please select:   Supported by the manufacturer's prescribing information for the patient's diagnosis?   Yes   No   Is the requested dose and frequency supported by the manufacturer's prescribing information for the patient's diagnosis?   Yes   No   Is the supporting information attached?   Acute graft versus host disease   Yes   No   Is the requested quantity supported by dosing guidelines found in the compendia or current literature (e.g., Micromedex DrugDex, NCCN compendia, current treatment guidelines)?   Yes   No   Is the requested drug being prescribed by or in consultation with an oncologist or hematologist?   Yes   No   Has the patient experienced an intolerance to corticosteroids?   Yes   No   Yes   No   No   Has the patient experienced an intolerance to corticosteroids?   Yes   No   No   Yes   Y							
Yes   No   sthe requested quantity supported by the manufacturer's prescribing information or dosing guidelines found in the compendia or current literature (e.g., Micromedex DrugDex, NCCN compendia, current treatment guidelines)?   Please select.   Supported by the manufacturer's prescribing information   Supported by the manufacturer's prescribing information   Supported by dosing guidelines found in the compendia or current literature   Supported by dosing guidelines found in the compendia or current literature (e.g., Micromedex DrugDex, NCCN compendia, current treatment guidelines)?   Yes   No   Is the requested quantity supported by dosing guidelines found in the compendia or current literature (e.g., Micromedex DrugDex, NCCN compendia, current treatment guidelines)?   Yes   No   Is the requested drug being prescribed by or in consultation with an oncologist or hematologist?   Section   Yes   No   Is the requested drug being prescribed by or in consultation with an oncologist or hematologist?   Yes   No   Hos the patient experienced an intolerance to corticosteroids?   Yes   No   Hos the patient experienced an intolerance to corticosteroids?   Yes   No   Hos the patient experienced an intolerance to corticosteroids?   Yes   No   Hos the patient experienced an intolerance to corticosteroids?   Yes   No   Hos the patient   Active ankylosing spondylitis (AS)   Active non-validigraphic axial spondyloarthritis   Please indicate loading dose at weeks 0, 2 and 6;   Please indicate maintenance dose:   frequency:   weeks   Yes   No   Hos the patient ever received or is currently receiving a biologic (e.g., Humira) or targeted synthetic drug (e.g., Rinvoq, Xeljanz) that is indicated for active ankylosing spondylitis (AS)   Active non-validigraphic axial spondyloarthritis (nr-axSpA)   Yes   No   Hos the patient experienced an inadequate response with at least TWO nonsteroidal anti-inflammatory drugs (NSAIDs), or has an intolerance or contraindication to at least TWO NSAIDs?   No   No   No   No   No   No   No   N							
literature (e.g., Micromedex DrugDex, NCCN compendia, current treatment guidelines)?   Please select.   Supported by the manufacturer's prescribing information   patient's diagnosis?   Supported by dosing guidelines found in the compendia or current literature   patient's diagnosis?   Acute graft versus host disease   Supported by dosing guidelines found in the compendia or current literature (e.g., Micromedex DrugDex, NCCN compendia, current treatment guidelines)?   Supported by dosing guidelines found in the compendia or current literature (e.g., Micromedex DrugDex, NCCN compendia, current treatment guidelines)?   Supported by or in consultation with an oncologist or hematologist?   Supported by dosing guidelines found in the compendia or current literature (e.g., Micromedex DrugDex, NCCN compendia, current treatment guidelines)?   Supported by Supported by or in consultation with an oncologist or hematologist?   Supported by Supported by or in consultation with an oncologist or hematologist?   Supported by Supported by Supported by Or in consultation with a rheumatologist?   Supported by							
Please select:   Supported by the manufacturer's prescribing information   Supported by the manufacturer's prescribing information for the patient's diagnosis?   Supported by dosing guidelines found in the compendia or current literature   Supported by dosing guidelines found in the compendia or current literature (e.g., Micromedex DrugDex, NCCN compendia, current treatment guidelines)?   Yes   No Is the requested drug being prescribed by or in consultation with an oncologist or hematologist?   Yes   No Is the requested drug being prescribed by or in consultation with an oncologist or hematologist?   Yes   No Has the patient experienced an inadequate response to systemic corticosteroids?   Ankylosing spondylitis and Non-radiographic axial spondyloarthritis   Yes   No Does the patient have a contraindication to corticosteroids?   Ankylosing spondylitis and Non-radiographic axial spondyloarthritis   Yes   No Is the requested drug being prescribed by or in consultation with a rheumatologist?   Wes   No Is the requested drug being prescribed by or in consultation with a rheumatologist?   Yes   No Is the requested drug being prescribed by or in consultation with a rheumatologist?   Yes   No Has the patient experienced an inadequate response with at least TWO nonsteroidal anti-inflammatory drugs (NSAIDs), or has an intolerance or contraindication to at least TWO NSAIDs?   See   No Is the requested drug being prescribed by or in consultation with a rheumatologist?   Yes   No Is the requested drug being prescribed by or in consultation with a rheumatologist?   Yes   No Is the requested drug being prescribed by or in consultation with a rheumatologist (e.g., Micromedex DrugDex, NCCN compendia, current treatment guidelines)?   Yes   No Is the requested drug being prescribed by or in consultation with a rheumatologist?   Yes   No Is the requested drug being prescribed by or in consultation with a rheumatologist?   Yes   No Is the requested drug being prescribed by or in consultation with a rheumatologist?   Yes   No Is th				delines found in the compendia or current			
patient's diagnosis?	→ Please sele	ect: U Supported by the manufacturer's prescri	bing information				
Supported by dosing guidelines found in the compendia or current literature			and frequency supported by the mai	nufacturer's prescribing information for the			
Acute graft versus host disease   Yes   No   Is the requested quantity supported by dosing guidelines found in the compendia or current literature (e.g., Micromedex DrugDex, NCCN compendia, current treatment guidelines)?   Yes   No   Is the requested drug being prescribed by or in consultation with an oncologist or hematologist?   Yes   No   Has the patient experienced an inadequate response to systemic corticosteroids?   Yes   No   Has the patient experienced an intolerance to corticosteroids?   Ankylosing spondylitis and Non-radiographic axial spondyloarthritis   Please indicate loading dose at weeks 0, 2 and 6:   Please indicate maintenance dose:   frequency:   weeks   Please select which of the following applies to the patient:   Active ankylosing spondylitis (AS)   Active non-radiographic axial spondyloarthritis (nr-axSpA)     Yes   No   Is the requested drug being prescribed by or in consultation with a rheumatologist?   Yes   No   Has the patient ever received or is currently receiving a biologic (e.g., Humira) or targeted synthetic drug (e.g., Rinvoq, Xeljanz) that is indicated for active ankylosing spondylitis or active non-radiographic axial spondyloarthritis?   Yes   No   Is the requested quantity supported by dosing guidelines found in the compendia or current literature (e.g., Micromedex DrugDex, NCCN compendia, current treatment guidelines)?   Yes   No   Is the requested drug being prescribed by or in consultation with a rheumatologist?   Yes   No   Is the requested drug being prescribed by or in consultation with a rheumatologist?   Yes   No   Is the requested drug being prescribed by or in consultation with a rheumatologist?   Yes   No   Is the requested drug being prescribed by or in consultation with a rheumatologist?   Yes   No   Is the requested drug being prescribed by or in consultation with a rheumatologist?   Yes   No   No   No   No   No   No   No   N		patient's diagnosis?	41				
Yes   No   Is the requested quantity supported by dosing guidelines found in the compendia or current literature (e.g., Micromedex DrugDex, NCCN compendia, current treatment guidelines)?   See   No   Is the requested drug being prescribed by or in consultation with an oncologist or hematologist?   See   No   Has the patient experienced an inadequate response to systemic corticosteroids?   Has the patient experienced an intolerance to corticosteroids?   Has the patient experienced an intolerance to corticosteroids?   Ankylosing spondylitis and Non-radiographic axial spondyloarthritis   Please indicate loading dose at weeks 0, 2 and 6:   Please indicate maintenance dose:   frequency:   weeks   Please indicate thich of the following applies to the patient:   Active ankylosing spondylitis (AS)   Active non-radiographic axial spondyloarthritis (nr-axSpA)   See   No   Is the requested drug being prescribed by or in consultation with a rheumatologist?   See   No   Has the patient ever received or is currently receiving a biologic (e.g., Humira) or targeted synthetic drug (e.g., Rinvoq, Xeljanz) that is indicated for active ankylosing spondylitis or active non-radiographic axial spondyloarthritis?   Yes   No   Has the patient experienced an inadequate response with at least TWO nonsteroidal anti-inflammatory drugs (NSAIDs), or has an intolerance or contraindication to at least TWO NSAIDs?   Yes   No   Is the requested drug being prescribed by or in consultation with a rheumatologist?   Yes   No   Has the patient ever received or is currently receiving Otezla or a biologic (e.g., Humira) indicated for the treatment of Behçet's disease (excluding receiving the drug via samples or a manufacturer's patient assistance program)?   Yes   No   Has the patient ever received or is currently receiving Otezla or a biologic (e.g., Humira) indicated for the treatment of Behçet's disease (e.g., apremilast, colchicine, systemic glucocorticoids, azathioprine)?   Yes   No   Does the prescriber recognize that a dose above 5 mg per kg i		Supported by dosing guidelines found in	the compendia or current literature				
Yes			mation attached?				
compendia, current treatment guidelines)?    Yes   No   Is the requested drug being prescribed by or in consultation with an oncologist or hematologist?   Yes   No   Has the patient experienced an inadequate response to systemic corticosteroids?   Yes   No   Has the patient experienced an intolerance to corticosteroids?   Yes   No   Does the patient have a contraindication to corticosteroids?   Ankylosing spondylitis and Non-radiographic axial spondyloarthritis   Please indicate loading dose at weeks 0, 2 and 6:	•		1.5 (1)				
Yes   No			ound in the compendia or current lite	rature (e.g., Micromedex DrugDex, NCCN			
Yes			n with an anadogist or homotologist				
Yes   No   Las the patient experienced an intolerance to corticosteroids?							
Ankylosing spondylitis and Non-radiographic axial spondyloarthritis  Please indicate loading dose at weeks 0, 2 and 6:							
Ankylosing spondylitis and Non-radiographic axial spondyloarthritis  Please indicate loading dose at weeks 0, 2 and 6: lease indicate maintenance dose: frequency: weeks  Please select which of the following applies to the patient: Active ankylosing spondylitis (AS)   Active non-radiographic axial spondyloarthritis (nr-axSpA)     Yes							
Please indicate loading dose at weeks 0, 2 and 6: Please indicate maintenance dose: frequency: weeks Please select which of the following applies to the patient: Active ankylosing spondylitis (AS) Active non-radiographic axial spondyloarthritis (nr-axSpA)   Yes							
Please select which of the following applies to the patient: Active ankylosing spondylitis (AS) Active non-radiographic axial spondyloarthritis (nr-axSpA) so Is the requested drug being prescribed by or in consultation with a rheumatologist?  Yes No Has the patient ever received or is currently receiving a biologic (e.g., Humira) or targeted synthetic drug (e.g., Rinvoq, Xeljanz) that is indicated for active ankylosing spondylitis or active non-radiographic axial spondyloarthritis?  Has the patient experienced an inadequate response with at least TWO nonsteroidal anti-inflammatory drugs (NSAIDs), or has an intolerance or contraindication to at least TWO NSAIDs?  Behcet's disease  Yes No Is the requested quantity supported by dosing guidelines found in the compendia or current literature (e.g., Micromedex DrugDex, NCCN compendia, current treatment guidelines)?  Yes No Is the requested drug being prescribed by or in consultation with a rheumatologist?  Has the patient ever received or is currently receiving Otezla or a biologic (e.g., Humira) indicated for the treatment of Behçet's disease (excluding receiving the drug via samples or a manufacturer's patient assistance program)?  Crohn's disease  Please indicate loading dose at weeks 0, 2 and 6: Please indicate maintenance dose: frequency: weeks  For under 18 years of age only:  Yes No Does the prescriber recognize that a dose above 5 mg per kg is a higher dose and the prescriber confirms that appropriate monitoring will be done?  Yes No Does the prescribed dose exceed an induction dose of 10 mg per kg at week 0, week 2, and week 6, and a maintenance dose of 10 mg per kg thereafter?			e maintenance dose: fre	quency: weeks			
Yes	Please select which of the f	ollowing applies to the patient: Active ankylo	sing spondylitis (AS) Active non	-radiographic axial spondyloarthritis (nr-axS	SpA)		
indicated for active ankylosing spondylitis or active non-radiographic axial spondyloarthritis?    Yes					. ,		
Yes   No   Has the patient experienced an inadequate response with at least TWO nonsteroidal anti-inflammatory drugs (NSAIDs), or has an intolerance or contraindication to at least TWO NSAIDs?    Behçet's disease   Yes   No   Is the requested quantity supported by dosing guidelines found in the compendia or current literature (e.g., Micromedex DrugDex, NCCN compendia, current treatment guidelines)?   Yes   No   Is the requested drug being prescribed by or in consultation with a rheumatologist?   Yes   No   Has the patient ever received or is currently receiving Otezla or a biologic (e.g., Humira) indicated for the treatment of Behçet's disease (excluding receiving the drug via samples or a manufacturer's patient assistance program)?   Yes   No   Has the patient had an inadequate response to at least one nonbiologic medication for Behçet's disease (e.g., apremilast, colchicine, systemic glucocorticoids, azathioprine)?   Crohn's disease   Please indicate loading dose at weeks 0, 2 and 6:	☐ Yes ☐ No Has the pa	tient ever received or is currently receiving a bio	ologic (e.g., Humira) or targeted syntl	netic drug (e.g., Rinvoq, Xeljanz) that is			
has an intolerance or contraindication to at least TWO NSAIDs?  Behçet's disease  Yes No Is the requested quantity supported by dosing guidelines found in the compendia or current literature (e.g., Micromedex DrugDex, NCCN compendia, current treatment guidelines)?  Yes No Is the requested drug being prescribed by or in consultation with a rheumatologist?  Yes No Has the patient ever received or is currently receiving Otezla or a biologic (e.g., Humira) indicated for the treatment of Behçet's disease (excluding receiving the drug via samples or a manufacturer's patient assistance program)?  Yes No Has the patient had an inadequate response to at least one nonbiologic medication for Behçet's disease (e.g., apremilast, colchicine, systemic glucocorticoids, azathioprine)?  Crohn's disease  Please indicate loading dose at weeks 0, 2 and 6: Please indicate maintenance dose: frequency: weeks  For under 18 years of age only:  No Does the prescriber recognize that a dose above 5 mg per kg is a higher dose and the prescriber confirms that appropriate monitoring will be done?  Yes No Does the prescribed dose exceed an induction dose of 10 mg per kg at week 0, week 2, and week 6, and a maintenance dose of 10 mg per kg thereafter?  All requests:  Yes No Has the patient been diagnosed with moderately to severely active Crohn's disease (CD)?	indicated fo	or active ankylosing spondylitis or active non-rac	diographic axial spondyloarthritis?				
Behçet's disease    Yes   No   Is the requested quantity supported by dosing guidelines found in the compendia or current literature (e.g., Micromedex DrugDex, NCCN compendia, current treatment guidelines)?   Yes   No   Is the requested drug being prescribed by or in consultation with a rheumatologist?   Yes   No   Has the patient ever received or is currently receiving Otezla or a biologic (e.g., Humira) indicated for the treatment of Behçet's disease (excluding receiving the drug via samples or a manufacturer's patient assistance program)?   Yes   No   Has the patient had an inadequate response to at least one nonbiologic medication for Behçet's disease (e.g., apremilast, colchicine, systemic glucocorticoids, azathioprine)?   Crohn's disease   Please indicate loading dose at weeks 0, 2 and 6: Please indicate maintenance dose: frequency: weeks	└── ☐ Yes ☐	No Has the patient experienced an inadequa	te response with at least TWO nonst	eroidal anti-inflammatory drugs (NSAIDs), c	or		
Yes       No       Is the requested quantity supported by dosing guidelines found in the compendia or current literature (e.g., Micromedex DrugDex, NCCN compendia, current treatment guidelines)?         Yes       No       Is the requested drug being prescribed by or in consultation with a rheumatologist?         Yes       No       Has the patient ever received or is currently receiving Otezla or a biologic (e.g., Humira) indicated for the treatment of Behçet's disease (excluding receiving the drug via samples or a manufacturer's patient assistance program)?         Wes       No       Has the patient had an inadequate response to at least one nonbiologic medication for Behçet's disease (e.g., apremilast, colchicine, systemic glucocorticoids, azathioprine)?         Crohn's disease       Please indicate loading dose at weeks 0, 2 and 6: Please indicate maintenance dose: frequency: weeks         For under 18 years of age only: Yes No       Does the prescriber recognize that a dose above 5 mg per kg is a higher dose and the prescriber confirms that appropriate monitoring will be done? No         Wes       No       Does the prescribed dose exceed an induction dose of 10 mg per kg at week 0, week 2, and week 6, and a maintenance dose of 10 mg per kg thereafter?         All requests: Yes       No       Has the patient been diagnosed with moderately to severely active Crohn's disease (CD)?		has an intolerance or contraindication to a	it least TWO NSAIDs?				
compendia, current treatment guidelines)?    Yes   No   Is the requested drug being prescribed by or in consultation with a rheumatologist?   Yes   No   Has the patient ever received or is currently receiving Otezla or a biologic (e.g., Humira) indicated for the treatment of Behçet's disease (excluding receiving the drug via samples or a manufacturer's patient assistance program)?   Yes   No   Has the patient had an inadequate response to at least one nonbiologic medication for Behçet's disease (e.g., apremilast, colchicine, systemic glucocorticoids, azathioprine)?   Crohn's disease   Please indicate loading dose at weeks 0, 2 and 6:   Please indicate maintenance dose:   frequency:   weeks   For under 18 years of age only:   Yes   No   Does the prescriber recognize that a dose above 5 mg per kg is a higher dose and the prescriber confirms that appropriate monitoring will be done?   Yes   No   Does the prescribed dose exceed an induction dose of 10 mg per kg at week 0, week 2, and week 6, and a maintenance dose of 10 mg per kg thereafter?   All requests:   No   Has the patient been diagnosed with moderately to severely active Crohn's disease (CD)?							
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Yes							
(excluding receiving the drug via samples or a manufacturer's patient assistance program)?    Yes				and for the treatment of Debect's disease			
Yes   No   Has the patient had an inadequate response to at least one nonbiologic medication for Behçet's disease (e.g., apremilast, colchicine, systemic glucocorticoids, azathioprine)?    Crohn's disease   Please indicate loading dose at weeks 0, 2 and 6: Please indicate maintenance dose: frequency: weeks				ed for the treatment of Bençet's disease			
colchicine, systemic glucocorticoids, azathioprine)?  Crohn's disease  Please indicate loading dose at weeks 0, 2 and 6: Please indicate maintenance dose: frequency:weeks  For under 18 years of age only:  Yes No Does the prescriber recognize that a dose above 5 mg per kg is a higher dose and the prescriber confirms that appropriate monitoring will be done?  Yes No Does the prescribed dose exceed an induction dose of 10 mg per kg at week 0, week 2, and week 6, and a maintenance dose of 10 mg per kg thereafter?  All requests:  Yes No Has the patient been diagnosed with moderately to severely active Crohn's disease (CD)?	(excluding i	No. Has the natient had an inadequate respon	nse to at least one nonhiologic medic	ation for Rehoet's disease (e.g. anremilast			
Crohn's disease  Please indicate loading dose at weeks 0, 2 and 6: Please indicate maintenance dose: frequency: weeks  For under 18 years of age only:  Yes No Does the prescriber recognize that a dose above 5 mg per kg is a higher dose and the prescriber confirms that appropriate monitoring will be done?  Yes No Does the prescribed dose exceed an induction dose of 10 mg per kg at week 0, week 2, and week 6, and a maintenance dose of 10 mg per kg thereafter?  All requests:  Yes No Has the patient been diagnosed with moderately to severely active Crohn's disease (CD)?	/ L 163 L	colchicine systemic glucocorticoids azat	nioprine)?	ation for benger's disease (e.g., aprenilast,	,		
For under 18 years of age only:  Yes No Does the prescriber recognize that a dose above 5 mg per kg is a higher dose and the prescriber confirms that appropriate monitoring will be done?  Yes No Does the prescribed dose exceed an induction dose of 10 mg per kg at week 0, week 2, and week 6, and a maintenance dose of 10 mg per kg thereafter?  All requests:  Yes No Has the patient been diagnosed with moderately to severely active Crohn's disease (CD)?	Crohn's disease	, - <b>,</b>					
<ul> <li>Yes</li></ul>	Please indicate loading dos	e at weeks 0, 2 and 6: Please indicate	e maintenance dose: fre	quency:weeks			
done?  Yes No Does the prescribed dose exceed an induction dose of 10 mg per kg at week 0, week 2, and week 6, and a maintenance dose of 10 mg per kg thereafter?  All requests: Yes No Has the patient been diagnosed with moderately to severely active Crohn's disease (CD)?	For under 18 years of age of	only:					
Yes No Does the prescribed dose exceed an induction dose of 10 mg per kg at week 0, week 2, and week 6, and a maintenance dose of 10 mg per kg thereafter?  All requests: Yes No Has the patient been diagnosed with moderately to severely active Crohn's disease (CD)?	☐ Yes ☐ No Does the p	rescriber recognize that a dose above 5 mg per	kg is a higher dose and the prescrib	er confirms that appropriate monitoring will	be		
dose of 10 mg per kg thereafter?  All requests:  Yes No Has the patient been diagnosed with moderately to severely active Crohn's disease (CD)?							
All requests:  Yes No Has the patient been diagnosed with moderately to severely active Crohn's disease (CD)?	└────────────────────────────────────		iction dose of 10 mg per kg at week	0, week 2, and week 6, and a maintenance			
Yes No Has the patient been diagnosed with moderately to severely active Crohn's disease (CD)?	A.II	dose of 10 mg per kg thereafter?					
		tiont book diagnosed with moderately to	ly active Crobn's disease (CD)2				



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

Aetna Precertification Notification Phone: <u>1-866-752-7021</u> (TTY: <u>711</u>)

FAX: <u>1-888-267-3277</u>

For Medicare Advantage Part B: Please Use Medicare Request Form

Patient First Name	Patient Last Name	Patient Phone	Patient DOB			
C. CLINICAL INFORMATION (confineral)	Descripted aliminal information mount by according	lakad in ika ankinak Kamall muaanki				
	<ul> <li>Required clinical information must be comp</li> </ul>	leted in its <u>entirety</u> for all precertif	ication requests.			
Is the requested quantity supported by dosing guidelines found in the compendia or current literature (e.g., Micromedex DrugDex, NCCN compendia, current treatment guidelines)?  Yes □ No Has the patient been diagnosed with severe, refractory hidradenitis suppurativa? □ Yes □ No Has the patient ever received or is currently receiving a biologic (e.g., Humira) indicated for the treatment of severe, refractory hidradenitis suppurativa (excluding receiving the drug via samples or a manufacturer's patient assistance program)? □ Yes □ No Has the patient experienced an inadequate response after at least 90 days of treatment with an oral antibiotic? □ Yes □ No Has the patient experienced an intolerance to oral antibiotics? □ Yes □ No Does the patient have a contraindication to oral antibiotics?						
		a contrainated for to oral antibiol				
Yes No Is the requested quantity s compendia, current treatm  Yes No Is the requested drug bein Has the patient experience  Yes No Has the p	mmune checkpoint inhibitor (e.g., CTLA-4, PD-L1 inhibitor) toxicity					
Immune checkpoint inhibitor (e.g., CTLA	4, PD-L1 inhibitor) toxicity – (Immunother					
	supported by dosing guidelines found in the co		., Micromedex DrugDex, NCCN			
☐ Yes ☐ No Does the patient have sev	· · · · · · · · · · · · · · · · · · ·					
Yes No Is the requested drug being Yes No Has the patient experience	ng prescribed by or in consultation with an onced an inadequate response to corticosteroids	?				
· ·	atient experienced an intolerance to corticoste					
	No Does the patient have a contraindication	on to corticosteroids?				
☐ Yes ☐ No ☐ Has the patient been diagroup of the requested drug bein ☐ Yes ☐ No ☐ Has the patient ever receindicated for the treatment assistance program)?  ☐ Yes ☐ No ☐ Are crucia ☐ Please income of BSA:	2 and 6: Please indicate maintenance nosed with moderate to severe plaque psorias ag prescribed by or in consultation with a derm wed or is currently receiving a biologic (e.g., Hit of moderate to severe plaque psoriasis (excludal body areas (e.g., hands, feet, face, neck, so dicate the percentage of body surface area (Barthala and San	is? atologist? umira) or targeted synthetic drug uding receiving the drug via samp alp, genitals/groin, intertriginous a SA) affected (prior to starting the	(e.g., Sotyktu, Otezla) les or a manufacturer's patient areas) affected? requested medication):%			
	eatient experienced an inadequate response, o plogic treatment with methotrexate, cyclosporir		apy (e.g., UVB, PUVA) or			
	No Does the patient have a clinical reason and acitretin?	to avoid pharmacologic treatmen				
	→ Please indicate clinical reason to avoid disorder, alcoholic liver disease or othe ☐ Pregnancy or currently planning preduction ☐ Risk of treatment-related toxicity ☐ kidney disease, blood dyscrasias, unco	r chronic liver disease ☐ Breas gnancy ☐ History of intolerance Significant comorbidity prohibits	tfeeding  Drug interaction or adverse event  Hypersensitivity use of systemic agents (e.g., liver or			
Psoriatic arthritis with or without co-exis	· · ·					
Please indicate loading dose at weeks 0, 2		e dose: frequency: _	weeks			
Please indicate which of the following appl  WITH co-existent plaque psoriasis	ies to the patient:					
	being treated as the primary diagnosis?					
Please go to <b>plaque p</b>	soriasis section					
	☐ Yes ☐ No Has the patient been diagnosed with active psoriatic arthritis (PsA)? ☐ Yes ☐ No Is the requested drug being prescribed by or in consultation with a rheumatologist or dermatologist?					



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

Aetna Precertification Notification Phone: <u>1-866-752-7021</u> (TTY: <u>711</u>)

FAX: <u>1-888-267-3277</u>

For Medicare Advantage Part B: Please Use Medicare Request Form

Patient Dos Patien				
Yes   No   Has the patient ever received or is currently receiving a biologic (e.g., Humriar) or targeted synthetic drug (e.g., Rinvor, Otezla) indicated for active positions cartific (sectuding receiving the drug via samples or a manufacturer's patient assistance program)?   Yes   No   Does the patient have mitted to moderate disease?   Yes   No   Does the patient have evere disease?   Yes   No   Does the patient have evere disease?   Yes   No   Does the patient have entheastis or predominantly axial disease?   Wes   No   Does the patient have entheastis or predominantly axial disease?   Wes   No   Does the patient have entheastis or predominantly axial disease?   Wes   No   Does the patient have a contraindication to another conventional synthetic drug (e.g., sulfasslazine)   Yes   No   Does the patient have a contraindication to another conventional synthetic drug (e.g., sulfasslazine)   Yes   No   Does the patient have a contraindication to another conventional synthetic drug (e.g., sulfasslazine)   Yes   No   Does the patient have a contraindication to another conventional synthetic drug (e.g., sulfasslazine)   Yes   No   Does the patient have a contraindication to another conventional synthetic drug (e.g., sulfasslazine)   Yes   No   Does the patient have a contraindication to another conventional synthetic drug (e.g., sulfasslazine)   Yes   No   Does the patient have a contraindication to another conventional synthetic drug (e.g., sulfasslazine)   Yes   No   Secondary of the sulfasslazine)   Yes   No   Secondary of the sulfasslazine   Yes   No   No   Secondary of the sulfasslazine   Yes   No	Patient First Name	Patient Last Name	Patient Phone	Patient DOB
Yes   No   Has the patient ever received or is currently receiving a biologic (e.g., Humriar) or targeted synthetic drug (e.g., Rinvor, Otezla) indicated for active positions cartific (sectuding receiving the drug via samples or a manufacturer's patient assistance program)?   Yes   No   Does the patient have mitted to moderate disease?   Yes   No   Does the patient have evere disease?   Yes   No   Does the patient have evere disease?   Yes   No   Does the patient have entheastis or predominantly axial disease?   Wes   No   Does the patient have entheastis or predominantly axial disease?   Wes   No   Does the patient have entheastis or predominantly axial disease?   Wes   No   Does the patient have a contraindication to another conventional synthetic drug (e.g., sulfasslazine)   Yes   No   Does the patient have a contraindication to another conventional synthetic drug (e.g., sulfasslazine)   Yes   No   Does the patient have a contraindication to another conventional synthetic drug (e.g., sulfasslazine)   Yes   No   Does the patient have a contraindication to another conventional synthetic drug (e.g., sulfasslazine)   Yes   No   Does the patient have a contraindication to another conventional synthetic drug (e.g., sulfasslazine)   Yes   No   Does the patient have a contraindication to another conventional synthetic drug (e.g., sulfasslazine)   Yes   No   Does the patient have a contraindication to another conventional synthetic drug (e.g., sulfasslazine)   Yes   No   Secondary of the sulfasslazine)   Yes   No   Secondary of the sulfasslazine   Yes   No   No   Secondary of the sulfasslazine   Yes   No				
Yes   No Does the patient have millot om oderard disease?   Yes   No Does the patient have millot om oderard disease?   Yes   No Does the patient have server disease?   Yes   No Does the patient have entheatis or predominantly axial disease?   Yes   No Does the patient have entheatis or predominantly axial disease?   Yes   No Does the patient have entheatis or predominantly axial disease?   Yes   No Does the patient have entheatis or written that on intolerance to methotrexate, leftunomide, or another conventional synthetic drug (e.g., sulfasalizarine) administered at an adequate dose and duration?   Yes   No Does the patient have a contraindication to methotrexate or refundance or conventional synthetic drug (e.g., sulfasalizarine)?   Yes   No Does the patient have a contraindication to methotrexate or refundance or conventional synthetic drug (e.g., sulfasalizarine)?   Yes   No Does the patient have a contraindication to another conventional synthetic drug (e.g., sulfasalizarine)?   Yes   No Does the patient have a contraindication to another conventional synthetic drug (e.g., sulfasalizarine)?   Yes   No Does the patient have a contraindication to another conventional synthetic drug (e.g., sulfasalizarine)?   Yes   No   Yes   No   Yes				
Significant comorbidity prohibits use of systemic agents (e.g., liver or kidney disease, blood dyscrasias, uncontrolled hypertension)   Hypersensitivity   History of intolerance or adverse event   Other:   History of intolerance or adverse event   Other:   History of intolerance or adverse event   Other:   Hypersensitivity   Hypers	Yes ☐ No Has the patient ever received of indicated for active psoriatic and Yes ☐ No Does the patient ☐ Yes ☐ Yes ☐ No Does The Patient ☐ Yes	or is currently receiving a biologic (e.g. thritis (excluding receiving the drug vint have mild to moderate disease?  No Does the patient have severe disent have enthesitis or predominantly and have the patient had an inadequate drug (e.g., sulfasalazine) adminises yes No Has the patient synthetic drug (e.g., valfasalazine) adminises yes No Has the patient synthetic drug (e.g., valfasalazine) Alpha Please indicated Clinical dia	g., Humira) or targeted synthetic drugia samples or a manufacturer's patientese?  axial disease?  te response to methotrexate, lefluno stered at an adequate dose and durath had an intolerance to methotrexate, (e.g., sulfasalazine)?  Does the patient have a contraind Yes \( \sum No \) Does the patient conventional syntes the contraindication:	g (e.g., Rinvoq, Otezla) ent assistance program)?  mide, or another conventional synthetic tion? leflunomide, or another conventional ication to methotrexate or leflunomide? have a contraindication to another thetic drug (e.g., sulfasalazine)?  nolic liver disease or other chronic liver
Pyoderma gangrenosum    Yes   No   Is the requested drug being prescribed by or in consultation with a dermatologist?   Yes   No   Is the requested drug being prescribed by or in consultation with a dermatologist?   Yes   No   Has the patient ever received or is currently receiving a biologic (e.g., Humina) indicated for the treatment of pyoderma gangrenosum (excluding receiving the drug via samples or a manufacturer's patient assistance program)?   Yes   No   Has the patient experienced an inadequate response with corticosteroids or immunosuppressive therapy (e.g., cyclosporine, mycophenolate mofetil)?   Yes   No   Has the patient experienced an intolerance to corticosteroids and immunosuppressive therapy (e.g., cyclosporine, mycophenolate mofetil)?   Yes   No   State requested quantity supported by dosing guidelines found in the compendia or current literature (e.g., Micromedex DrugDex, NCCN compendia, current treatment guidelines);   State requested drug being prescribed by or in consultation with a rheumatologist?   Also the patient ever received or is currently receiving a biologic (e.g., Enbrel) indicated for the treatment of reactive arthritis (excluding receiving the drug via samples or a manufacturer's patient assistance program)?   Yes   No   Has the patient experienced an inadequate response after at least 3 months of treatment with either of the following:   a) sulfasalazine at a dose of 1000 mg twice daily or maximally tolerated dose, or b) methotrexate at a dose greater than or equal to 15 mg per week or maximally tolerated dose;   Yes   No   Has the patient experienced an inadequate response after at least 3 months of treatment with either of the following:   a) sulfasalazine at a dose of 1000 mg twice daily or maximally tolerated dose;   Yes   No   Has the patient experienced an inadequate response after at least 3 months of treatment with either of the following:   a) sulfasalazine (e.g., porphyria, intestinal or urinary obstruction)?   Yes   No   Dose the patient have a contraindication to met		☐ Significant blood dyscras ☐ History of i	comorbidity prohibits use of systemi ias, uncontrolled hypertension)  ntolerance or adverse event	c agents (e.g., liver or kidney disease,
Yes   No   Is the requested quantity supported by dosing guidelines found in the compendia or current literature (e.g., Micromedex DrugDex, NCCN compendia, current treatment guidelines)?   Is the requested drug being prescribed by or in consultation with a dermatologist?   Has the patient ever received or is currently receiving a biologic (e.g., Humira) indicated for the treatment of pyoderma gangrenosum (excluding receiving the drug via samples or a manufacturer's patient assistance program?)?   Yes   No   Has the patient experienced an inadequate response with corticosteroids or immunosuppressive therapy (e.g., cyclosporine, mycophenolate mofetil)?   Yes   No   Has the patient experienced an intolerance to corticosteroids and immunosuppressive therapy (e.g., cyclosporine, mycophenolate mofetil)?   Yes   No   Sis the requested drug being prescribed by or in consultation with a rheumatologist?   Is the requested drug being prescribed by or in consultation with a rheumatologist?   Is the requested drug being prescribed by or in consultation with a rheumatologist?   Is the requested drug being prescribed by or in consultation with a rheumatologist?   Is the requested drug being prescribed by or in consultation with a rheumatologist?   Is the requested drug being prescribed by or in consultation with a rheumatologist?   Is the requested drug being prescribed by or in consultation with a rheumatologist?   Is the requested drug being prescribed by or in consultation with a rheumatologist?   Is the requested drug being prescribed by or in consultation with a rheumatologist?   Is the requested drug being prescribed by or in consultation with a rheumatologist?   Is the requested drug being prescribed by or in consultation with a rheumatologist?   Is the requested drug being prescribed by or in consultation with a rheumatologist?   Is the requested drug being prescribed by or in consultation with a rheumatologist?   Is the requested drug being prescribed by or in consultation with a rheumatologist?   Is the requested		∐ Other:	<del></del>	
	Yes No Is the requested quantity support compendia, current treatment of Is the requested drug being properties.  Yes No Has the patient ever received or receiving the drug via samples.  Yes No Has the patient mycophenolat.	guidelines)? escribed by or in consultation with a cor is currently receiving a biologic (e.g. or a manufacturer's patient assistance the experienced an inadequate response mofetil)?  Has the patient experienced an interpretation cyclosporine, mycophenolate mofes   Yes  No Does the patient the	dermatologist? g., Humira) indicated for the treatment ce program)? se with corticosteroids or immunosus colerance to corticosteroids and immetall)? nave a contraindication to corticoster	nt of pyoderma gangrenosum (excluding ppressive therapy (e.g., cyclosporine, unosuppressive therapy (e.g.,
compendia, current treatment guidelines)?  Is the requested drug being prescribed by or in consultation with a rheumatologist?  Has the patient ever received or is currently receiving a biologic (e.g., Enbrel) indicated for the treatment of reactive arthritis (excluding receiving the drug via samples or a manufacturer's patient assistance program)?  Yes No Has the patient experienced an inadequate response after at least 3 months of treatment with either of the following:  a) sulfasalazine at a dose of 1000 mg twice daily or maximally tolerated dose, or b) methotrexate at a dose greater than or equal to 15 mg per week or maximally tolerated dose;  Yes No Has the patient experienced an intolerance to sulfasalazine and methotrexate?  Yes No Does the patient have a contraindication to sulfasalazine (e.g., porphyria, intestinal or urinary obstruction)?  Yes No Does the patient have a contraindication to methotrexate?  Please indicate the contraindication:  Clinical diagnosis of alcohol use disorder, alcoholic liver disease or other chronic liver disease Drug interaction Risk of treatment-related toxicity  Pregnancy or currently planning pregnancy Breastfeeding  Significant comorbidity prohibits use of systemic agents (e.g., liver or kidney disease, blood dyscrasias, uncontrolled hypertension) Hypersensitivity		orted by dosing quidelines found in th	ne compendia or current literature (e	a Micromedex DrugDex NCCN
Yes   No   Is the requested drug being prescribed by or in consultation with a rheumatologist?   Has the patient ever received or is currently receiving a biologic (e.g., Enbrel) indicated for the treatment of reactive arthritis (excluding receiving the drug via samples or a manufacturer's patient assistance program)?   Yes   No   Has the patient experienced an inadequate response after at least 3 months of treatment with either of the following:   a) sulfasalazine at a dose of 1000 mg twice daily or maximally tolerated dose, or b) methotrexate at a dose greater than or equal to 15 mg per week or maximally tolerated dose?   Yes   No   Does the patient have a contraindication to sulfasalazine (e.g., porphyria, intestinal or urinary obstruction)?   Yes   No   Does the patient have a contraindication to methotrexate?   Please indicate the contraindication:   Clinical diagnosis of alcohol use disorder, alcoholic liver disease or other chronic liver disease   Drug interaction   Risk of treatment-related toxicity   Pregnancy or currently planning pregnancy   Breastfeeding   Significant comorbidity prohibits use of systemic agents (e.g., liver or kidney disease, blood dyscrasias, uncontrolled hypertension)   Hypersensitivity   History of intolerance or adverse event			le compendia or current illerature (e.	g., Micromedex Drugbex, NCCN
obstruction)?  Yes No Does the patient have a contraindication to methotrexate?  Please indicate the contraindication:  Clinical diagnosis of alcohol use disorder, alcoholic liver disease or other chronic liver disease Drug interaction Risk of treatment-related toxicity  Pregnancy or currently planning pregnancy Breastfeeding  Significant comorbidity prohibits use of systemic agents (e.g., liver or kidney disease, blood dyscrasias, uncontrolled hypertension) Hypersensitivity  History of intolerance or adverse event	☐ Yes ☐ No Is the requested drug being precipitation of the drug via samples or a manual year. ☐ Yes ☐ No Has the patient a) sulfasalazing than or equal to ☐ Yes ☐ No	escribed by or in consultation with a representation with a representation of the consultation with a representation of the consultation of the co	g., Enbrel) indicated for the treatmen m)? se after at least 3 months of treatmer maximally tolerated dose, or b) met ated dose? olerance to sulfasalazine and metho	nt with either of the following: hotrexate at a dose greater trexate?
		·	nave a contraindication to sulfasalazi	ne (e.g., porphyria, intestinal or urinary
☐ Significant comorbidity prohibits use of systemic agents (e.g., liver or kidney disease, blood dyscrasias, uncontrolled hypertension) ☐ Hypersensitivity ☐ History of intolerance or adverse event		☐ Yes ☐ No I Please indicate t ☐ Clinical dia disease ☐ Di	the contraindication:  Ignosis of alcohol use disorder, alcobrug interaction    Risk of treatment	nolic liver disease or other chronic liver -related toxicity
		☐ Significant blood dyscras ☐ History of i	comorbidity prohibits use of systemi ias, uncontrolled hypertension)	c agents (e.g., liver or kidney disease,



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

Aetna Precertification Notification Phone: <u>1-866-752-7021</u> (TTY: <u>711</u>)

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For Medicare Advantage Part B: Please Use Medicare Request Form

Patient First Nar	me	Patient Last Name	Patient Phone	Patient DOB			
G. CLINICAL IN	G. CLINICAL INFORMATION (continued) – Required clinical information must be completed in its entirety for all precertification requests.						
Rheumatoid art		•	·	·			
	loading dose at weeks 0, 2 and	6: Please indicate maintenance	dose: frequency:	weeks			
		d with moderately to severely active rheur					
☐ Yes ☐ No	Is the requested drug being pre	escribed by or in consultation with a rheun	natologist?				
☐ Yes ☐ No	Has the patient ever received of	or is currently receiving a biologic (e.g., Hเ	umira) or targeted synthetic drug	(e.g., Rinvoq, Xeljanz) indicated			
	, ,	re rheumatoid arthritis (excluding receiving	g the drug via samples or a manu	facturer's patient assistance			
	program)?						
		nt meet either of the following: a) the patie					
		ker test was positive, or b) the patient was CP biomarker test was positive?	s tested for the anti-cyclic citrulling	ated peptide (anti-CCP) biomarker			
		o Has the patient been tested for all of th	e following biomarkers: a) rheum	atoid factor (RF), b) anti-cyclic			
	/ L 165 L 14	citrullinated peptide (anti-CCP), and c)					
	☐ Yes ☐ No Is the requeste	ed medication being prescribed in combination					
		e a clinical reason for the patient to not us					
	☐ Clinical dia	agnosis of alcohol use disorder, alcoholic	liver disease or other chronic live	disease Drug interaction			
		atment-related toxicity  ☐ Pregnancy or					
		comorbidity prohibits use of systemic age		blood dyscrasias, uncontrolled			
	,	☐ Hypersensitivity ☐ History of intoler	ance or adverse event				
	Other:						
	☐ Yes ☐ No	Does the patient have other reason or	no clinical reason not to use metr	iotrexate or letiunomide?			
	V Yes □ No	Has the patient experienced an inadeq	uate response after at least 3 mo	onths of treatment with methotrevate			
	/ L 103 L 11	at a dose greater than or equal to 15 m		This of troublent with motifolioxate			
		$\rightarrow$ $\square$ Yes $\square$ No Has the patient experie	enced an intolerance to methotrexa	te?			
		Yes No Does	the patient have a contraindication ntraindication:	on to methotrexate?			
		•		lic liver disease or other chronic liver			
		_ •	nteraction	•			
			urrently planning pregnancy []				
		_ •	, ,	agents (e.g., liver or kidney disease,			
			Incontrolled hypertension)	/persensitivity			
		☐ Other:	rance or adverse event				
	— > □ Vos □ No. Is the	requested medication being prescribed in	combination with mothetrevate of	or loflunomido?			
		e indicate a clinical reason for the patient					
	•	Clinical diagnosis of alcohol use disorde					
		Drug interaction    Risk of treatment-re					
		Breastfeeding Significant comorbidit					
		ood dyscrasias, uncontrolled hypertension					
	☐ Other:						
	No clinical reason not to use methotrexate or leflunomide						
Sarcoidosis							
☐ Yes ☐ No	Yes No Is the requested quantity supported by dosing guidelines found in the compendia or current literature (e.g., Micromedex DrugDex, NCCN						
□ Vaa □ Na	compendia, current treatment guidelines)? ☐ Yes ☐ No Is the requested drug being prescribed by or in consultation with a dermatologist or pulmonologist?						
		escribed by or in consultation with a derma i inadequate response with corticosteroids		(e.g. azathionrine methotrevate)?			
		t experienced an intolerance to corticoste					
	methotrexate?	•		17 (9.,			
	Yes No Does the patient have a contraindication to corticosteroids and immunosuppressive therapy (e.g., azathioprine,						
			The controctor order and infiling the	, , , , , , , , , , , , , , , , , , , ,			



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

Aetna Precertification Notification Phone: <u>1-866-752-7021</u> (TTY: <u>711</u>)

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For Medicare Advantage Part B: Please Use Medicare Request Form

Patient First Name	Patient Last Name	Patient Phone	Patient DOB				
G. CLINICAL INFORMATION (continued) – Required clinical information must be completed in its entirety for all precertification requests.							
Takayasu's arteritis	'	<del></del>	·				
Yes No Is the requested quantity supported by dosing guidelines found in the compendia or current literature (e.g., Micromedex DrugDex, NCCN compendia, current treatment guidelines)?							
Yes No Has the patient been diag							
			ive thereny (e.g. methetrevete, ezethienrine				
mycophenolate mofetil)?	☐ Yes ☐ No Has the patient experienced an inadequate response with corticosteroids or immunosuppressive therapy (e.g., methotrexate, azathioprine, mycophenolate mofetil)?  ☐ Yes ☐ No Has the patient experienced an intolerance to corticosteroids and immunosuppressive therapy (e.g., methotrexate,						
azathiop	rine, mycophenolate mofetil)?	·					
	No Does the patient have a con- methotrexate, azathioprine, i	traindication to corticosteroids ar mycophenolate mofetil)?	nd immunosuppressive therapy (e.g.,				
Ulcerative colitis	0 10 51 11 1						
Please indicate loading dose at weeks 0,	2 and 6: Please indicate m	aintenance dose: fr	requency:weeks				
For under 18 years of age only:  Yes No Does the prescriber recognition will be done?	gnize that a dose above 5 mg per kg	is a higher dose and the prescri	ber confirms that appropriate monitoring				
Yes No Does the prescribed dose thereafter?	e exceed an induction dose of 10 mg	g per kg at week 0, week 2, and v	week 6, and a maintenance dose of 10 mg per kg				
All requests:  ☐ Yes ☐ No Has the patient been dia	gnosed with moderately to severely a	active ulcerative colitis (UC)?					
☐ Yes ☐ No Is the requested drug bei	ng prescribed by or in consultation v	vith a gastroenterologist?					
Uveitis							
		nd in the compendia or current lit	erature (e.g., Micromedex DrugDex, NCCN				
compendia, current treati		vith an onhthalmologist or rheum	atologist?				
			treatment of uveitis (excluding receiving the drug				
via samples or a manufac	cturer's patient assistance program)?	?`	, , , ,				
Yes No Has the	patient experienced an inadequate r rine, mycophenolate mofetil)?	esponse with corticosteroids or in	mmunosuppressive therapy (e.g., methotrexate,				
└── ☐ Yes	☐ No Has the patient experienced	an intolerance to corticosteroids	and immunosuppressive therapy (e.g.,				
	methotrexate, azathioprine,						
			corticosteroids and immunosuppressive therapy				
	, ,	trexate, azathioprine, mycophen	olate mofetil)?				
For Continuation Requests (clinical doc							
Please indicate maintenance dose:  Yes No Is the patient currently re	frequency:weeks		ont assistance program?				
			uidelines found in the compendia or current				
	ex DrugDex, NCCN compendia, cur		uldelines lound in the compendia of current				
Please select:  Suppor	ted by the manufacturer's prescribin	a information					
			anufacturer's prescribing information for the				
	ted by dosing guidelines found in the ses No Is the supporting informa						
•	ES INO IS THE SUPPORTING INTORMA	mon attacheu?					
Acute graft versus host disease	ng proscribed by or in consultation w	with an ancologist or homotologis	+2				
Yes No Is the requested drug bei	ced an inadequate response to syste	emic corticosteroids?					
Yes No Does the patient have an intolerance or contraindication to corticosteroids?							
Ankylosing spondylitis and Non-radiographic axial spondyloarthritis  Please select which of the following applies to the patient:  Active ankylosing spondylitis (AS)  Active non-radiographic axial spondyloarthritis (nr-axSpA)							
Yes No Is the requested drug bei			Ti-radiographic axial spondyloaitinitis (III-axopA)				
Yes No Has the patient achieved			se activity or improvement in signs and				
	on since starting treatment with the r		, ,				
	the following the patient has experie						
	otal spinal pain 🔲 inflammation (e	.g., morning stiffness) $\square$ none	of the above				
Behcet's disease							
Yes No Is the requested drug bei							
Yes No Has the patient achieved		,	se activity or improvement in signs and				
symptoms of the condition	n since starting treatment with the re	quested drug?					



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

Aetna Precertification Notification Phone: <u>1-866-752-7021</u> (TTY: <u>711</u>)

FAX: <u>1-888-267-3277</u>

**For Medicare Advantage Part B:** Please Use Medicare Request Form

Patient First Name	Patient Last Name	Patient Phone	Patient DOB
G. CLINICAL INFORMATION (continued) – Re	equired clinical information must be comp	leted in its <u>entirety</u> for all precertif	ication requests.
Crohn's disease  ☐ Yes ☐ No Has the patient been diagnose ☐ Yes ☐ No Is the requested drug being pre- For under 18 years of age only:			
Yes No Does the prescriber recognize be done?	that a dose above 5 mg per kg is a highe	r dose and the prescriber confirm	s that appropriate monitoring will
For 18 years of age or older only:  Please select which applies to this request:  Yes No Is the requested drug for an action of the patient require a dose All requests:	dult patient following loss of response?		ose
Yes No Does the prescribed dose exceed Yes No Has the patient achieved or matching Yes No Has the patient			disease activity or improvement in
└────────────────────────────────────	Is this request for an increase in dosing at the current dose?	regimen due to the patient not a	
	e which of the following the patient has expain or tenderness		
	e of the mucosa on endoscopy, computed stinal ultrasound		
	<u>above applies</u> : ☐ Yes ☐ No Is this req an adequ	uest for an increase in dosing reg ate clinical response at the currer	
Hidradenitis suppurativa  Yes No Has the patient been diagnose Yes No Is the requested drug being pre Has the patient achieved or ma of the condition since starting to Please indicate which of the following the patien reduction in abscess and inflammatory nodu decrease in frequency of inflammatory lesion improvement in frequency of relapses from to improvement on a disease severity assessm Immune checkpoint inhibitor (e.g., CTLA-4, P Yes No Is the requested drug being pre	escribed by or in consultation with a rheur sintained a positive clinical response as extreatment with the requested drug? In this experienced since starting treatment ecount from baseline reduced form the from baseline reduced form the from baseline reduction in pain from baseline reduction in pain from baseline reduction in quality of life the front tool from baseline reduction in pain from the front tool from baseline reduction in quality of life the front baseline reduction in pain from the front tool from baseline reduction in pain front tool from baseline reduction with the front tool front t	natologist or dermatologist? videnced by low disease activity of nt with the requested drug: ation of new sinus tracts and scal im baseline	ring
Yes No Has the patient experienced are Yes Yes No Has the patient experienced are Yes No Has the patient experienced are Yes No Has the patient experienced are Yes No	n inadequate response to corticosteroids? It experienced an intolerance to corticoste  Does the patient have a contraindicatio  ☐ Yes ☐ No Does the patient have	eroids? n to corticosteroids? cardiac toxicity?	
Immune checkpoint inhibitor (e.g., CTLA-4, P  ☐ Yes ☐ No Is the requested drug being pre ☐ Yes ☐ No Has the patient achieved or man of the condition since starting to	escribed by or in consultation with an onc aintained a positive clinical response as e	ologist or hematologist?	or improvement in signs and symptoms
Plaque psoriasis or Psoriatic arthritis WITH  ☐ Yes ☐ No Has the patient been diagnose	d with moderate to severe plaque psorias		
Yes No Is the requested drug being pre			or improvement in signs and symptoms
Yes No Has the patient experienced a Yes No Has the patien			n baseline (e.g., itching, redness,
Psoriatic arthritis WITHOUT co-existent plaquer Yes No Is the requested drug being pre	ue psoriasis	natologist or dermatologist?	
Yes No Has the patient achieved or ma symptoms of the condition since Please indicate which of the following Please indicate which plea		videnced by low disease activity or rug? provement in from baseline:	
none of the above  Pyoderma gangrenosum			
Yes No Is the requested drug being present Yes No Has the patient achieved or masymptoms of the condition since		videnced by low disease activity of	or improvement in signs and
Reactive arthritis  ☐ Yes ☐ No Is the requested drug being pre	escribed by or in consultation with a rheur	natologist?	
☐ Yes ☐ No Has the patient achieved or ma	•	videnced by low disease activity	



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

Aetna Precertification Notification Phone: 1-866-752-7021 (TTY: 711)

FAX: <u>1-888-267-3277</u>

For Medicare Advantage Part B: Please Use Medicare Request Form

Patient First Nai	ne	Patient Last Name	Patient Phone	Patient DOB			
0. 01 10110 41 101	FORMATION (see stime of the	and the state of t	to the state of th				
	. CLINICAL INFORMATION (continued) – Required clinical information must be completed in its entirety for all precertification requests.						
	heumatoid arthritis						
	Yes No Has the patient been diagnosed with moderately to severely active rheumatoid arthritis (RA)?						
	No Is the requested drug being prescribed by or in consultation with a rheumatologist? No Is this a request for a change in dosing regimen?						
_		0 0					
		e above 3 mg per kg due to an incomplete					
_		g more frequent than every 8 weeks due to	·	surrent dosing frequency?			
_	,	nly: Is the requested drug for an adult patie	nt with incomplete response?				
_	Does the prescribed dose exc	01 0					
ſ		aintained a positive clinical response since	-	=			
$ \longmapsto $		nt experienced substantial disease activity in	mprovement (e.g., at least 20% f	rom baseline) in tender joint count,			
	swollen joint count, pain, or disability?						
	→ ☐ Yes ☐ No	Is this a request for an increase in dosing		achieving an adequate clinical			
		response at the current dose or frequence	sy?				
Sarcoidosis							
		escribed by or in consultation with a derma					
☐ Yes ☐ No		aintained a positive clinical response as evi		r improvement in signs and			
	symptoms of the condition since starting treatment with the requested drug?						
Takayasu's arte							
		ed with refractory Takayasu's arteritis?					
	☐ No Is the requested drug being prescribed by or in consultation with a rheumatologist?						
∐ Yes ∐ No	Yes No Has the patient achieved or maintained a positive clinical response as evidenced by low disease activity or improvement in signs and						
symptoms of the condition since starting treatment with the requested drug?							
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							
		ally false information or conceals materia		of misleading, commits a fraudulent			
insurance act v	which is a crime and subjects.	such person to criminal and civil penaltie	25				

The plan may request additional information or clarification, if needed, to evaluate requests.