Cosentyx (secukinumab)
Prior Authorization Request Form

Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

MEMBER'S LAST NAME: _____ **MEMBER'S FIRST NAME:** _____

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

☐ **URGENT**

MEMBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PHONE NUMBER:	**DATE OF BIRTH:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
PATIENT INSURANCE ID NUMBER:	

☐ **MALE** ☐ **FEMALE** **HEIGHT (IN/CM):** _____ **WEIGHT (LB/KG):** _____ **ALLERGIES:** _____

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: HTTPS://MAGELLANRX.COM/MEMBER/EXTERNAL/COMMERCIAL/COMMON/DOC/EN-US/PHI_DISCLOSURE_AUTHORIZATION.PDF

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): _____
AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: _____

PRESCRIBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PRESCRIBER SPECIALTY:	**EMAIL ADDRESS:**
NPI NUMBER:	**DEA NUMBER:**
PHONE NUMBER:	**FAX NUMBER:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
REQUESTOR (if different than prescriber)**:**	**OFFICE CONTACT PERSON:**

MEDICATION OR MEDICAL DISPENSING INFORMATION			
MEDICATION NAME:			
DOSE/STRENGTH:	**FREQUENCY:**	**LENGTH OF THERAPY/REFILLS:**	**QUANTITY:**
☐ **NEW THERAPY** ☐ **RENEWAL** **IF RENEWAL:** DATE THERAPY INITIATED:			
DURATION OF THERAPY (SPECIFIC DATES):			

Continued on next page.

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1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? ☐ YES (if yes, complete below) ☐ NO		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE)**:**	**DURATION OF THERAPY** (SPECIFY DATES)**:**	**RESPONSE/REASON FOR FAILURE/ALLERGY:**

2. LIST DIAGNOSES:		**ICD-10:**
☐ Ankylosing spondylitis	☐ Juvenile Psoriatic Arthritis	
☐ Plaque psoriasis	☐ Active Enthesitis-related arthritis	
☐ Psoriatic arthritis	☐ Hidradenitis suppurativa	
☐ Non-radiographic axial spondyloarthritis		
☐ Other Diagnosis_____-ICD-10 Code(s):_____		

3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.

Clinical information:
Will this drug be used as part of a clinical trial? ☐ Yes ☐ No

<u>For initial request</u>:

Will Cosentyx be used concurrently with another tumor necrosis factor (TNF) inhibitor? ☐ Yes ☐ No

Select if Cosentyx is being prescribed by one of the following specialists:
☐ Dermatologist ☐ Rheumatologist

Has the patient tried and had an inadequate response to a three month trial of Enbrel? ☐ Yes ☐ No *Must provide documentation, including trial dates.*

Has the patient tried and had an inadequate response to a three month trial of Humira? ☐ Yes ☐ No *Must provide documentation, including trial dates.*

For <u>plaque psoriasis</u>, also answer the following:
Does the patient have plaques covering at least 3% of their body surface area (BSA)? ☐ Yes ☐ No

Are plaques covering < 3% of BSA, but with involvement of palms, soles, head and neck, or genitalia which causes disruption of normal activities? ☐ Yes ☐ No *Must provide chart note documentation

Has the patient had inadequate response to a topical therapy (e.g., corticosteroids, anthralin, calcipotriene, tazarotene)? ☐ Yes ☐ No
If "yes" to the above question, document the agent(s) that have been tried and trial dates:
_____

Has the patient had a trial and had inadequate response to phototherapy options with psoralens with UV A light (PUVA) or UVB with coal tar? ☐ Yes ☐ No
If "yes" to the above question, document the agent(s) that have been tried and trial dates:
_____

MEMBER'S LAST NAME: _____ **MEMBER'S FIRST NAME:** _____

Has the patient had a trial and had inadequate response to at least one oral systemic therapy (i.e., acitretin, methotrexate, or cyclosporine)? □ **Yes** □ **No**
If "yes" to the above question, document the agent(s) that have been tried and trial dates:
_____

If "no" to the above question, does the patient have contraindications to all three oral systemic therapies (acitretin AND methotrexate AND cyclosporine)?* □ **Yes** □ **No**

Please submit documentation of the contraindications to all three drugs.

For ankylosing spondylitis, also answer the following:
Has the patient had an adequate trial and failure of at least two non-steroidal anti-inflammatory agents (NSAIDs) or is use with these agents contraindicated? □ **Yes** □ **No**
If "yes" to the above question, document the agent(s) that have been tried and/or contraindications to therapy:_____

Has the patient been treated with methotrexate AND has had adequate trial and failure of one NSAID? □ **Yes** □ **No**
If "yes" to the above question, document the agent(s) that have been tried :
_____

For psoriatic arthritis, also answer the following:

Has the patient had at least a 3 month trial and failed previous therapy with an oral non-biologic disease modifying anti-rheumatic agent (DMARD) (e.g., methotrexate, azathioprine (Imuran), sulfasalazine (Azulfidine), or leflunomide (Arava))? □ **Yes** □ **No**

Is the patient unable to take the prerequisite non-biologic DMARD due to their chronic liver disease (such as chronic hepatitis, fatty liver, nonalcoholic steatohepatitis/NASH, or elevated liver enzymes)? □ **Yes** □ **No**
If "no" to the above question, provide the rationale as to why the patient has not taken the prequisite non-biologic DMARD:_____
_____

For non-radiographic axial spondyloarthritis, also answer the following:
Does the patient have objective signs of inflammation by presence of sacroiliitis on MRI imaging results?
□ **Yes** □ **No** ***Please submit MRI imaging report.***

Does the patient have objective signs of inflammation by presence of an elevated C-reactive protein level?
□ **Yes** □ **No** ***Please submit lab report.***

Has the patient had an inadequate response to at least two different NSAIDs
□ **Yes** □ **No** ***Please submit documentation.***

Is the patient taking high-potency opioid analgesics? □ **Yes** □ **No**

Has the patient had prior treatment with an IL-17 antagonist (such as Taltz)? □ **Yes** □ **No**

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Does the patient have radiographic (x-ray) evidence of sacroiliitis (grade 2 or greater bilaterally OR grade 3 or higher unilaterally) □ Yes □ No *Please submit imaging (x-ray) report*.

For <u>Moderate to Severe active Juvenile Psoriatic Arthritis</u> also answer the following:
Is the medication being used in combination with methotrexate? □ Yes □ No

Has the patient had an adequate trial and failure of at least one non-steroidal anti-inflammatory agent (NSAID) for at least one month or is use with these agents contraindicated? □ Yes □ No
If "yes" to the above question, document the agent(s) that have been tried and/or contraindications to therapy:_____

Has the patient been treated and had adequate trial and failure with an oral disease-modifying anti-rheumatic agent (DMARD) (methotrexate, leflunoide etc) for at least one month or is use with these agents contraindicated? □ Yes □ No
If "yes" to the above question, document the agent(s) that have been tried :
_____

For <u>Active Enthesitis-related Arthritis</u> also answer the following:

Has the patient had an adequate trial and failure of at least one non-steroidal anti-inflammatory agent (NSAID) for at least one month or is use with these agents contraindicated? □ Yes □ No
If "yes" to the above question, document the agent(s) that have been tried and/or contraindications to therapy:_____

Has the patient been treated and had adequate trial and failure with an oral disease-modifying anti-rheumatic agent (DMARD) (methotrexate, leflunoide etc) for at least one month or is use with these agents contraindicated? □ Yes □ No
If "yes" to the above question, document the agent(s) that have been tried :
_____

<u>Renewal Criteria:</u>
Is prescriber a dermatologist or rheumatologist? □ Yes □ No

Is patient continuing to have a positive response to therapy? □ Yes □ No *Please submit chart documentation.*

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

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Please note: Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received.

ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or 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 or Electronic I.D. Verification: _____ **Date:** _____

FAX THIS FORM TO: 800-424-7640
MAIL REQUESTS TO: Magellan Rx Management Prior Authorization Program
Attn: CP - 4201
P.O. Box 64811
St. Paul, MN 55164-0811