Cosentyx (Secukinumab)
Prior Authorization Request Form

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

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** DURATION OF THERAPY (SPECIFIC DATES):		**IF RENEWAL:** DATE THERAPY INITIATED:	

Continued on next page.

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

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 □ Plaque psoriasis □ Psoriatic arthritis □ Other Diagnosis_____-ICD-10 Code(s):_____	

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

Clinical information: 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
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 plaque psoriasis, also answer the following:
Does the patient have plaques covering at least 3% of their body surface area (BSA)? □ Yes □ No
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 UVA 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:
_____

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:_____
_____

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

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; c/o Magellan Health, Inc.