



**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](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:
<input type="checkbox"/> NEW THERAPY	<input type="checkbox"/> 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? <input type="checkbox"/> YES (if yes, complete below) <input type="checkbox"/> NO		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE): 	DURATION OF THERAPY (SPECIFY DATES): 	RESPONSE/REASON FOR FAILURE/ALLERGY:
2. LIST DIAGNOSES:		ICD-10:
<input type="checkbox"/> Ankylosing spondylitis <input type="checkbox"/> Plaque psoriasis <input type="checkbox"/> Psoriatic arthritis <input type="checkbox"/> Non-radiographic axial spondyloarthritis <input type="checkbox"/> Other Diagnosis _____		
<input type="checkbox"/> Juvenile Psoriatic Arthritis <input type="checkbox"/> Active Enthesitis-related arthritis -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? <input type="checkbox"/> Yes <input type="checkbox"/> No For initial request: Will Cosentyx be used concurrently with another tumor necrosis factor (TNF) inhibitor? <input type="checkbox"/> Yes <input type="checkbox"/> No Select if Cosentyx is being prescribed by one of the following specialists: <input type="checkbox"/> Dermatologist <input type="checkbox"/> Rheumatologist Has the patient tried and had an inadequate response to a three month trial of Enbrel? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>*Must provide documentation, including trial dates.</i> Has the patient tried and had an inadequate response to a three month trial of Humira? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>*Must provide documentation, including trial dates.</i>		
For plaque psoriasis, also answer the following: Does the patient have plaques covering at least 3% of their body surface area (BSA)? <input type="checkbox"/> Yes <input type="checkbox"/> No Are plaques covering < 3% of BSA, but with involvement of palms, soles, head and neck, or genitalia which causes disruption of normal activities? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>*Must provide chart note documentation</i> Has the patient had inadequate response to a topical therapy (e.g., corticosteroids, anthralin, calcipotriene, tazarotene)? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes" to the above question, document the agent(s) that have been tried and trial dates: _____		





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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 prerequisite 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





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

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 **Moderate to Severe active Juvenile Psoriatic Arthritis** 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, leflunide 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 **Active Enthesitis-related Arthritis** 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, leflunide 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 :

Renewal Criteria:

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:** _____

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FAX THIS FORM TO: 800-424-7640

MAIL REQUESTS TO: Magellan Rx Management Prior Authorization Program; c/o Magellan Health, Inc.
4801 E. Washington Street, Phoenix, AZ 85034
Phone: 877-228-7909

