

## COSENTYX (secukinumab) (non-preferred) PRIOR AUTHORIZATION FORM

To review the prior authorization guidelines for Cosentyx, please refer to the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapter – Cytokine & CAM Antagonists (accessible at: <http://www.dhs.pa.gov/provider/pharmacyservices/drugsrequiringclinicalpriorauthorization/index.htm>).

PRIOR AUTHORIZATION REQUEST INFORMATION			PRESCRIBER INFORMATION		
<input type="checkbox"/> New request	<input type="checkbox"/> Additional info	# of pages in request: _____	Prescriber name: _____		
<input type="checkbox"/> Renewal request	(PA# _____)	_____	Specialty: _____		
Name of office contact: _____			State license #: _____		
Contact's phone number: _____			NPI: _____		
LTC facility contact/phone: _____			MA Provider ID#: _____		
RECIPIENT INFORMATION			Street address: _____		
Recipient Name: _____			Suite #: _____	City/State/Zip: _____	
Recipient ID#: _____	DOB: _____	Phone: _____	Fax: _____		

### CLINICAL INFORMATION

<b>Product requested:</b> <input type="checkbox"/> Cosentyx 300 mg dose <u>Sensoready pen</u> <input type="checkbox"/> Cosentyx 300 mg dose <u>syringe</u>		
Dose/directions: _____	Quantity: _____	Refills: _____
Recipient weight: _____	Diagnosis ( <i>submit documentation</i> ): _____	Dx code ( <i>required</i> ): _____
1. Cosentyx is part of the Department's Specialty Pharmacy Drug Program (SPDP). What Specialty Pharmacy will be used?		<input type="checkbox"/> Diplomat Specialty Pharmacy <input type="checkbox"/> Walgreens Specialty Pharmacy
2. Does the Recipient have a history of trial and failure, contraindication, or intolerance to the preferred agents in this class? <i>Check all that apply.</i> <input type="checkbox"/> Enbrel <input type="checkbox"/> Humira		<input type="checkbox"/> Yes – <i>submit all supporting documentation of preferred agents tried and failed, contraindications, or intolerances</i> <input type="checkbox"/> No
3. Is the Recipient being treated for one of the following diagnoses? <i>Check all that apply.</i> <input type="checkbox"/> ankylosing spondylitis <input type="checkbox"/> plaque psoriasis <input type="checkbox"/> psoriatic arthritis		<input type="checkbox"/> Yes – <i>submit documentation supporting diagnosis</i> <input type="checkbox"/> No – <i>submit medical literature supporting the use of Cosentyx for the Recipient's diagnosis</i>

**Initial requests: complete section applicable to Recipient's diagnosis; Renewal requests: complete renewal section**

#### Section A: Initial request – ankylosing spondylitis or psoriatic arthritis

1. Did the Recipient try and fail a 6-week trial of at least two different NSAIDs, or does the Recipient have a contraindication or intolerance to NSAIDs?	<input type="checkbox"/> Yes – <i>submit all supporting documentation of NSAIDs tried and failed, contraindications, or intolerances</i> <input type="checkbox"/> No
2. Did the Recipient try and fail at least 3 months of treatment with methotrexate or other DMARD? <i>Check all that apply.</i> <input type="checkbox"/> methotrexate <input type="checkbox"/> other DMARD (specify): _____	<input type="checkbox"/> Yes – <i>submit all supporting documentation of DMARDs tried and failed, contraindications, or intolerances</i> <input type="checkbox"/> No

#### Section B: Initial request – plaque psoriasis

1. Does either of the following apply to the Recipient's psoriasis? <i>Check option that applies.</i> <input type="checkbox"/> at least 10% of the body surface area (BSA) is affected <input type="checkbox"/> < 10% of the BSA is affected, but affected areas include critical areas of the body (face, palms, soles of feet, and/or genitals)	<input type="checkbox"/> Yes – <i>submit documentation</i> <input type="checkbox"/> No
2. Does the Recipient have a history of trial and failure, contraindication, or intolerance to the following? <i>Check all that apply.</i> <input type="checkbox"/> 3 months of PUVA <input type="checkbox"/> acitretin <input type="checkbox"/> methotrexate <input type="checkbox"/> 3 months of UVB light with either coal tar or dithranol <input type="checkbox"/> cyclosporine	<input type="checkbox"/> Yes – <i>submit documentation of therapies tried and failed, contraindications, or intolerances</i> <input type="checkbox"/> No

#### Section C: All renewal requests

1. <i>Submit documentation of how the requested medication has helped the Recipient's condition and level of functioning.</i>
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**PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION**

<b>Prescriber Signature:</b> _____	<b>Date:</b> _____
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