Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
Cosentyx (secukinumab) Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk
Length of Authorizations: Initial- 6 months; Continuation- 12 months

Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **Cosentyx (secukinumab).** Please complete all sections, incomplete forms will delay processing. Fax this form back to Kaiser Permanente within 24 hours fax: 1-866-331-2104. If you have any questions or concerns, please call 1-866-331-2103. **Requests will not be considered unless this form is complete. The KP-MAS Formulary can be found at:** Pharmacy | Community Provider Portal | Kaiser Permanente

1 – Patient Information

Patient Name: _____ Kaiser Medical ID#: _____ Date of Birth: _____

2 – Provider Information

Is the prescriber a Rheumatologist or Dermatologist? □ No □ Yes

If consulted with a specialist, specialist name and specialty: _____

Provider Name: _____ Specialty: _____ NPI: _____

Provider Address: _____

Provider Phone #: _____Provider Fax #: _____

3 – Pharmacy Information

Pharmacy Name: _____ Pharmacy NPI: _____

Pharmacy Phone #_____ Pharmacy Fax #: _____

4 – Drug Therapy Requested

Drug 1: Name/Strength/Formulation: _____
Sig: _____

Drug 2: Name/Strength/Formulation: _____
Sig: _____

5– Diagnosis/Clinical Criteria

1. Is this request for initial or continuing therapy?
   □ Initial therapy □ Continuing therapy, State start date: _____

2. Indicate the patient's diagnosis for the requested medication: _____

Clinical Criteria:

Rheumatology:

1. Member has diagnosis of psoriatic arthritis**,**
   □ No □ Yes

2. **AND** has history of inadequate response, contraindication, or intolerance to one or more medications to treat psoriatic arthritis such as conventional DMARDs (e.g. methotrexate or leflunomide) after a 3-month trial,
   □ No □ Yes

3. **AND** inadequate response, intolerance, or contraindication to adalimumab product [Amjevita (preferred), Humira]
   □ No □ Yes

--OR--

1. Member has diagnosis of active ankylosing spondylitis or nonradiographic axial spondyloarthritis,
   □ No □ Yes

2. **AND** inadequate response, contraindication, or intolerance to infliximab AND adalimumab product [Amjevita (preferred), Humira],
   □ No □ Yes

3. **AND** inadequate response, contraindication, or intolerance to full anti-inflammatory dose of an NSAID taken on a regular continuing basis for at least 4 weeks
   □ No □ Yes

--OR--

1. Documented presence of enthesitis/tendonitis as part of manifestation of peripheral spondyloarthritis
   □ No □ Yes

--OR--

1. Diagnosis of peripheral spondylarthritis and does not have enthesitis/tendonitis,
   □ No □ Yes

2. **AND** member has history of inadequate response or intolerance after 3 month trial of at least one nonbiologic DMARD such as sulfasalazine, methotrexate or leflunomide,
   □ No □ Yes

3. **AND** inadequate response, intolerance, or contraindication to adalimumab product [Amjevita (preferred), Humira]
   □ No □ Yes

Dermatology:

1. Member has diagnosis of moderate to severe plaque psoriasis (>3% body surface area unless palmar-plantar involvement is severe),
   □ No □ Yes

2. **AND** member has had inadequate response or contraindication to at least a 3-month trial of phototherapy unless involvement in sensitive areas (e.g., face, body folds, etc.),
   □ No □ Yes

3. **AND** member has failed at least a 3-month trial of 1 of the following unless clinically significant adverse effects, contraindication or clinical reason to avoid treatment (i.e. pregnancy/breastfeeding, history of alcoholism or alcoholic liver disease, chronic liver disease, immunodeficiency syndrome, pre-existing blood dyscrasia, hemodialysis, or end-stage renal disease)
   - Methotrexate,

- OR acitretin

□ No □ Yes

4. **AND** inadequate response (at least 3-month trial), intolerance, or contraindication to at least one of the preferred anti-TNF agents [i.e. adalimumab-atto (Amjevita) or infliximab-dyyb (Inflectra)]

□ No □ Yes

For continuation of therapy, please respond to <u>additional questions</u> below:

1. Member has documented a clinically significant benefit from medication,

□ No □ Yes

2. **AND** specialist follow-up occurred in past 12 months

□ No □ Yes

6 – Provider Sign-Off

Additional Information –

1. **Please submit chart notes/medical records for the patient that are applicable to this request.**
2. **If member has not tried preferred agent(s) please provide rationale/explanation and any additional supporting information that should be taken into consideration for the requested medication:**

_____

_____

_____

I certify that the information provided is accurate. Supporting documentation is available for State audits.

Provider Signature:	**Date:**