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:

If treating psoriatic arthritis:

1. Does the patient have a diagnosis of psoriatic arthritis?
   □ No □ Yes

2. Does the patient have a history of inadequate response after at least a 3-month trial, contraindication, or intolerance to at least ONE of the conventional DMARDs (e.g. methotrexate or leflunomide)?
   □ No □ Yes

3. Has the patient had an inadequate response, intolerance, or contraindication to adalimumab product [Amjevita (preferred), Humira]?
   □ No □ Yes

If treating spondylarthritis:

1. Has the patient had an inadequate response, contraindication, or intolerance to infliximab product (Inflectra preferred) or adalimumab product (Amjevita preferred)?
   □ No □ Yes

2. Does the patient meet at least ONE of the following conditions?
   - Diagnosis of active ankylosing spondylitis or nonradiographic axial spondyloarthritis, AND has had inadequate response, contraindication, or intolerance to full anti-inflammatory dose of an NSAID taken on a regular continuing basis for at least 4 weeks
   - Presence of enthesitis/tendinitis as part of manifestation of peripheral spondyloarthritis such as Achilles tendinopathy or plantar fasciitis
   - Diagnosis of peripheral spondyloarthritis (i.e. reactive arthritis, spondyloarthritis related to inflammatory bowel disease or other peripheral spondyloarthritis rather than axial), does NOT have enthesitis, AND has had inadequate response after a 3-month trial, contraindication, or intolerance to at least one nonbiologic DMARD such as sulfasalazine, methotrexate, or leflunomide
     □ No □ Yes

Dermatology:

If treating hidradenitis suppurativa:

1. Does the patient have a diagnosis of moderate-to-severe hidradenitis suppurativa?
   □ No □ Yes

2. Has the patient had an inadequate response, contraindication, or intolerance to at least THREE of the following therapies? *(Note: Significantly severe hidradenitis suppurativa may proceed with preferred TNF without trial of topical/oral antibiotics or intralesional corticosteroids)*
   - Topical clindamycin 1% solution/lotion/gel (minimum of 12 weeks)
   - Intralesional corticosteroids
   - Oral antibiotics (e.g., doxycycline, tetracycline, clindamycin +/- rifampin, erythromycin) (minimum of 10 weeks)
   - Adalimumab product (Amjevita preferred) or infliximab product (Inflectra preferred) (minimum of 12 weeks)
     □ No □ Yes

If treating plaque psoriasis:

1. Does the patient have a diagnosis of moderate to severe plaque psoriasis (>3% body surface area unless palmar-plantar involvement is severe)?
   □ No □ Yes

2. Has the patient had an inadequate response to at least a 3-month trial, contraindication or intolerance to phototherapy unless involvement in sensitive areas (e.g., face, body folds, etc.)?
   □ No □ Yes

3. Has the patient had an inadequate response to at least a 3-month trial of at least ONE 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
   - Acitretin

   □ No □ Yes

4. Has the patient had an 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. Has the patient had a clinically significant benefit from medication?
   □ No □ Yes

2. Has specialist follow-up occurred in past 12 months since last review?
   □ 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:**