COSENTYX (SECUKINUMAB) (PREFERRED) PRIOR AUTHORIZATION FORM

(form effective 1/5/21)

AmeriHealth Caritas Pennsylvania | PERFORMRX℠ Next Generation Pharmacy Benefits

Fax to PerformRx℠ at **1-888-981-5202**, or to speak to a representative call **1-866-610-2774.**

PRIOR AUTHORIZATION REQUEST INFORMATION

☐ New request ☐ Renewal request	# of pages:	Name of office contact:
Contact's phone number:		LTC facility contact/phone:

PATIENT INFORMATION

Patient name:	Patient ID #:	DOB:
Street address:	Apt. #:	City/state/zip:

PRESCRIBER INFORMATION

Prescriber name:	Specialty:	
State license #:	NPI:	MA Provider ID #:
Street address:	Suite #:	City/state/zip:
Phone:	Fax:	

CLINICAL INFORMATION

Product requested: ☐ Cosentyx 300 mg dose - 2 pens ☐ Cosentyx 300 mg dose - 2 syringes ☐ Cosentyx _____

Dose/directions:

Quantity:	Refills:	Patient weight:
Diagnosis *(submit documentation)*:		Dx code *(required)*:

PHARMACY INFORMATION (PRESCRIBER TO IDENTIFY THE PHARMACY THAT IS TO DISPENSE THE MEDICATION):

Deliver to: ☐ Patient's Home ☐ Physician's Office ☐ Patient's Preferred Pharmacy Name:

Pharmacy Phone #: Pharmacy Fax #:

☐ I acknowledge that the patient agrees with the pharmacy chosen for delivery of this medication.

INITIAL REQUESTS - COMPLETE SECTIONS APPLICABLE TO PATIENT'S DIAGNOSIS

1. ***All diagnoses:*** Is Cosentyx being prescribed by or in consultation with an appropriate specialist, such as a rheumatologist or dermatologist? ☐ Yes - List specialty ☐ No

2. ***All diagnoses:*** Have all potential drug interactions been addressed?
   ☐ Yes ☐ No ☐ N/A – No drug interactions exist

3. ***All diagnoses:*** Check all that apply to the patient.
   ☐ vaccinated for hepatitis B ☐ screened for hepatitis B (surface antigen and core antibody) ☐ up-to-date with all age-appropriate immunizations ☐ screened for tuberculosis

4. ***All diagnoses:*** Does the patient have a history of trial and failure, contraindication, or intolerance to the preferred agents? Check all that apply. ☐ Humira ☐ Enbrel ☐ Taltz

5. ***Psoriatic arthritis:*** Does at least one of the following apply to the patient?
   ☐ axial disease and/or enthesitis and has tried and failed a 2-week trial with 2 different oral NSAIDs; list medications tried: _____
   ☐ peripheral disease and has tried and failed methotrexate or other DMARD; list medications tried: _____
   ☐ severe disease ☐ concomitant moderate-to-severe nail disease

6. ***Ankylosing spondylitis or other axial spondyloarthritis:*** Does the patient have a history of trial and failure of a 2-week trial of continuous treatment with 2 different oral NSAIDs?
   ☐ Yes – List medications tried: _____ ☐ No

7. ***Plaque psoriasis:*** Does at least one of the following apply to the patient?
   ☐ at least 3% of the body surface area (BSA) is affected ☐ critical areas of the body are involved (face, palms, soles of feet, and/or genitals)
   ☐ significant disability or impairment of physical or mental functioning
   ☐ Yes ☐ No *Submit documentation of clinical response.*

8. ***Plaque psoriasis***: Does the patient have a history of trial and failure, contraindication, or intolerance to topical corticosteroids or other topical therapy?
   ☐ Yes – List medications tried: _____ ☐ No

9. ***Plaque psoriasis***: Does the patient have a history of trial and failure, contraindication, or intolerance to the following? Check all that apply.
   ☐ oral systemic therapy; list medications tried: List medications tried: _____
   ☐ ultraviolet light therapy

RENEWAL REQUESTS

1. Since starting Cosentyx, did the patient experience a positive clinical response and/or improved level of functioning? ☐ Yes ☐ No *Submit documentation of clinical response.*

2. Is Cosentyx being prescribed by or in consultation with an appropriate specialist, such as a rheumatologist or dermatologist?
   ☐ Yes – List specialty: _____ ☐ No

3. Have all potential drug interactions been addressed? ☐ Yes ☐ No ☐ N/A – no drug interactions exist

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION

Prescriber signature:	Date: