COSENTYX (SECUKINUMAB) (NON-PREFERRED) PRIOR AUTHORIZATION FORM

(form effective 1/9/2023)

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? ☐ Yes - List specialty ☐ No

2. ***All diagnoses:*** Check all that apply to the patient.
   ☐ screened for hepatitis B (anti-HBs, HBsAg, and anti-HBc) ☐ screened for tuberculosis

3. ***All diagnoses:*** Does the patient have a history of trial and failure, contraindication, or intolerance to the preferred Cytokine and CAM antagonists approved or medically accepted for their condition? Check all that apply.
   ☐ Avsola ☐ Enbrel ☐ Humira ☐ Infliximab Vial (authorized generic for Remicade) ☐ Orencia ☐ Otezla ☐ Simponi pen/syringe ☐ Taltz ☐ Xeljanz tablet

4. ***All diagnoses:*** Is the patient currently (in the last 90 days) receiving therapy with Cosentyx? ☐ Yes ☐ No

5. ***Psoriatic arthritis:*** Does at least one of the following apply to the patient?
   ☐ axial disease, dactylitis, and/or enthesitis
   ☐ has tried and failed methotrexate or other DMARD for at least 8 weeks; list medications tried or explain contraindication: _____
   ☐ concomitant active inflammatory bowel disease
   ☐ 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 – provide explanation: _____

7. ***Chronic psoriasis:*** Check all that apply to the patient.
   ☐ at least 3% of body surface area (BSA) is affected ☐ critical areas of the body are involved (such as face, palms, soles, and/or genitals)
   ☐ significant disability or impairment of physical, mental, or psychosocial functioning ☐ moderate to severe nail disease
   ☐ history of therapeutic failure, contraindication or intolerance to (check all that apply):
   ☐ 4-week trial of topical steroids or 8-week trial of other topical therapy; list medications tried or explain contraindication: _____
   ☐ 3-month trial of conventional systemic therapy; list medications tried or explain contraindication: _____
   ☐ phototherapy

8. ***Juvenile idiopathic arthritis (JIA):*** Check all that apply to the patient.
   ☐ therapeutic failure, contraindication or intolerance to a three-month trial of a conventional non-biologic DMARD; list medications tried or explain contraindication: _____
   ☐ systemic JIA with active systemic features
   ☐ one or more risk factors for disease severity
   ☐ involvement of high-risk joints (e.g. cervical spine, hip, wrist)
   ☐ high disease activity
   ☐ at high risk of disabling joint damage
   ☐ active sacroliitis and/or enthesitis and has tried and failed a two-week trial of an oral NSAID; list medications tried or explain contraindication: _____

RENEWAL REQUESTS

1. Since starting Cosentyx, did the patient experience improvement in disease activity and/or level of functioning? ☐ Yes ☐ No *Submit documentation of clinical response.*
2. Is Cosentyx being prescribed by or in consultation with an appropriate specialist?
   ☐ Yes – List specialty:_____ ☐ No

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION

Prescriber signature:	Date: