SENTARA HEALTH PLANS

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request.** All other information may be filled in by office staff; **fax to 1-800-750-9692.** No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If information provided is not complete, correct, or legible, authorization may be delayed.**

Drug Requested: Cosentyx® SQ (secukinumab) **(Pharmacy)**

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: ____

Member Sentara #: ____________________________ **Date of Birth:** ______________

Prescriber Name: ____

Prescriber Signature: ____________________________ **Date:** ______________

Office Contact Name: ____

Phone Number: ________________________ **Fax Number:** ____________________

DEA OR NPI #: ____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: ____

Dosing Schedule: ____________________________ **Length of Therapy:** ______________

Diagnosis: ____________________________ **ICD Code:** ____________________

Weight: ________________________ **Date:** ____________________

NOTE: The Health Plan considers the use of concomitant therapy with more than one biologic immunomodulator (e.g., Dupixent, Entyvio, Humira, Rinvoq, Stelara) prescribed for the same or different indications to be experimental and investigational. Safety and efficacy of these combinations has **NOT** been established and will **NOT** be permitted.

Recommended Dosing: (select **ONE** of the following)

- ❑ Prescribed with a loading dose
- ❑ Prescribed without a loading dose

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied. **Check the diagnosis below that applies.**

(Continued on next page)

❑ Diagnosis: Active Ankylosing Spondylitis

Dosing:
- ❑ **With a loading dose:** 150 mg at weeks 0, 1, 2, 3, and 4 followed by 150 mg every 4 weeks
- ❑ **Without a loading dose:** 150 mg every 4 weeks

- ❑ Member has a diagnosis of active **ankylosing spondylitis**
- ❑ Prescribed by or in consultation with a **Rheumatologist**
- ❑ Member tried and failed, has a contraindication, or intolerance to **TWO** NSAIDs
- ❑ Member meets **ONE** of the following:
  - ❑ Member tried and failed, has a contraindication, or intolerance to **TWO** of the **PREFERRED** biologics below:

❑ adalimumab product: Humira®, Cyltezo® or Hyrimoz®	❑ Enbrel®	❑ Rinvoq®
❑ Taltz®	❑ Xeljanz®/XR®	

  ***NOTE:** Humira NDC's starting with 83457 are not approved, NDC's starting with 00074 (MFG: Abbvie) are preferred; Hyrimoz NDC's starting with 83457 are not approved, NDC's starting with 61314 (MFG: Sandoz) are preferred

  - ❑ Member has been established on Cosentyx® for at least 90 days **AND** prescription claims history indicates **at least a 90-day supply of Cosentyx was dispensed within the past 130 days (verified by chart notes or pharmacy paid claims)**

❑ Diagnosis: Active Non-Radiographic Axial Spondyloarthritis

Dosing:
- ❑ **With a loading dose:** 150 mg at weeks 0, 1, 2, 3, and 4 followed by 150 mg every 4 weeks
- ❑ **Without a loading dose:** 150 mg every 4 weeks

- ❑ Member has a diagnosis of active **non-radiographic axial spondyloarthritis**
- ❑ Prescribed by or in consultation with a **Rheumatologist**
- ❑ Member has at least **ONE** of the following objective signs of inflammation:
  - ❑ C-reactive protein [CRP] levels above the upper limit of normal
  - ❑ Sacroiliitis on magnetic resonance imaging [MRI] (indicative of inflammatory disease, but without definitive radiographic evidence of structural damage on sacroiliac joints)
- ❑ Member tried and failed, has a contraindication, or intolerance to **TWO** NSAIDs
- ❑ Member meets **ONE** of the following:
  - ❑ Member tried and failed, has a contraindication, or intolerance to **TWO** of the following:

❑ Cimzia®	❑ Rinvoq®	❑ Taltz®

  - ❑ Member has been established on Cosentyx® for at least 90 days **AND** prescription claims history indicates **at least a 90-day supply of Cosentyx was dispensed within the past 130 days (verified by chart notes or pharmacy paid claims)**

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❑ Diagnosis: Active Psoriatic Arthritis or Active Enthesitis-related Arthritis

Dosing:
- ❑ **With a loading dose:** 150 mg at weeks 0, 1, 2, 3, and 4 followed by 150 mg every 4 weeks
- ❑ **Without a loading dose:** 150 mg every 4 weeks

- ❑ Member must meet **ONE** of the following age and diagnosis requirements:
  - ❑ Member is ≥ 2 years of age with a diagnosis of active **psoriatic arthritis**
  - ❑ Member is ≥ 4 years of age with a diagnosis of active **enthesitis-related arthritis**
- ❑ Prescribed by or in consultation with a **Rheumatologist or Dermatologist**
- ❑ Member has tried and failed at least **ONE** of the following **DMARD** therapies for at least **three (3) months**
  - ❑ cyclosporine
  - ❑ leflunomide
  - ❑ methotrexate
  - ❑ sulfasalazine
- ❑ Member meets **ONE** of the following:
  - ❑ Member tried and failed, has a contraindication, or intolerance to **TWO** of the **PREFERRED** biologics below **(verified by chart notes or pharmacy paid claims)**:

❑ adalimumab product: Humira®, Cyltezo® or Hyrimoz®	❑ Enbrel®	❑ Otezla®	❑ Rinvoq®
	❑ Skyrizi®	❑ Stelara®	❑ Taltz®
	❑ Tremfya®	❑ Xeljanz®/XR®	

*__NOTE:__ Humira NDC's starting with 83457 are not approved, NDC's starting with 00074 (MFG: Abbvie) are preferred; Hyrimoz NDC's starting with 83457 are not approved, NDC's starting with 61314 (MFG: Sandoz) are preferred

  - ❑ Member has been established on Cosentyx® for at least 90 days **AND** prescription claims history indicates **at least a 90-day supply of Cosentyx was dispensed within the past 130 days (verified by chart notes or pharmacy paid claims)**

❑ Diagnosis: Moderate-to-Severe Plaque Psoriasis

Dosing: ***Provider please note: Loading dose is required***
- ❑ Adults: 300 mg once weekly at weeks 0, 1, 2, 3, and 4 followed by 300 mg every 4 weeks
- ❑ Pediatric members 6 years and older: Recommended dosage based on body weight and administered by subcutaneous injection at Weeks 0, 1, 2, 3, and 4 and every 4 weeks thereafter

Body Weight at Time of Dosing	Recommended Dose
Less than 50 kg	75 mg
Greater than or equal to 50 kg	150 mg

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- ❑ Member is ≥ 6 years of age and has a diagnosis of **moderate-to-severe plaque psoriasis**
- ❑ Prescribed by or in consultation with a **Dermatologist**
- ❑ Member tried and failed at least **ONE** of either Phototherapy or Alternative Systemic therapy for at least **three (3) months (check all that apply):**

❑ **Phototherapy:**	❑ **Alternative Systemic Therapy:**
❑ **UV Light Therapy** ❑ NB UV-B ❑ PUVA	❑ **Oral Medications** ❑ acitretin ❑ methotrexate ❑ cyclosporine

- ❑ Member meets **ONE** of the following:
  - ❑ Member tried and failed, has a contraindication, or intolerance to **TWO** of the **PREFERRED** biologics below **(verified by chart notes or pharmacy paid claims)**:

❑ adalimumab products: Humira®, Cyltezo® or Hyrimoz®	❑ Enbrel®	❑ Otezla®	❑ Skyrizi®
	❑ Stelara®	❑ Taltz®	❑ Tremfya®

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  - ❑ Member has been established on Cosentyx® for at least 90 days **AND** prescription claims history indicates **at least a 90-day supply of Cosentyx was dispensed within the past 130 days (verified by chart notes or pharmacy paid claims)**

❑ **Diagnosis: Moderate-to-Severe Hidradenitis Suppurativa (HS)**
Dosing: SubQ: *Provider please note: Loading dose is required*
Initial: 300 mg administered by subcutaneous injection at Weeks 0, 1, 2, 3 and 4 (day 28).
Maintenance: 300 mg every 4 weeks (starting on day 56)

- ❑ Member is ≥ 18 years of age and has a diagnosis of moderate-to-severe **hidradenitis suppurativa**
- ❑ Prescribed by or in consultation with a **Dermatologist**
- ❑ Member tried and failed a 90-day course of oral antibiotics (e.g., tetracycline, minocycline, doxycycline or clindamycin, rifampin) for treatment of HS **(within last 9 months)**

  Name of Antibiotic & Date: ____

Medication being provided by a Specialty Pharmacy – Proprium Rx

*****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.*****

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****

***Approved by Pharmacy and Therapeutics Committee:** ~~7/16/2015; 8/17/2023;~~ **1/18/2024**
REVISED/UPDATED/REFORMATTED: ~~8/3/2017; 12/16/2017; 12/31/2018; 9/28/2019; 11/26/2019; 11/18/2020; 11/08/2021; 4/25/2022; 6/15/2022; 6/28/2022; 12/20/2022; 5/26/2023; 8/13/2023; 10/28/2023; 2/16/2024; 3/27/2024;~~ **4/29/2024**