SENTARA COMMUNITY PLAN
(MEDICAID)

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 the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: Cosentyx® SQ (secukinumab) **(self-administered) (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:** _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight (if applicable): _____ **Date weight obtained:** _____

Cosentyx® is available under both Medical and Pharmacy benefits
(Please select correct PA form)

DIAGNOSIS	Recommended Dose
❑ **Active Ankylosing Spondylitis**	• Five syringes/pens in the initial 28 days • One syringe/pen per 28 days after induction period. If patient continues to be symptomatic on above may increase to two syringes/pens per 28 days.
❑ **Active Non-Radiographic Axial Spondyloarthritis (nr-axSpA) – with objective signs of inflammation**	• Four syringes/pens in the initial 28 days • One syringe/pen per 28 days after induction period or one syringe/pen per 28 days without induction
❑ **Active Psoriatic Arthritis**	• Five syringes/pens in the initial 28 days • One syringe/pen per 28 days after induction period

(Continued on next page)

DIAGNOSIS	Recommended Dose
❑ **Active Enthesitis-related arthritis (ERA)**	• Weeks 0, 1, 2, 3, and every 4 weeks thereafter • Weight ≥ 15 kg and < 50 kg the dose is 75 mg • Weight ≥ 50 kg the dose is 150 mg
❑ **Moderate to Severe Chronic Plaque Psoriasis**	• Ten syringes/pens in the initial 28 days • Two syringes/pens per 28 days after induction period **Pediatric**: • < 50kg: Five pediatric 75mg syringes in initial 28 • days • One syringe per 28 days after induction period • >50kg: Ten pediatric 75mg syringes in initial 28 • days • Two syringes per 28 days after induction period
❑ **Moderate to Severe Hidradenitis Suppurative (HS)**	• 30 to <90kg: 150 at weeks 0, 1, 2, 3, 4 and every 4 weeks thereafter • 300 mg at weeks 0, 1, 2, 3, 4 and every 4 weeks thereafter • Dose may be increased to 300mg every 2 weeks if patient does not adequately respond

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.

❑ Diagnosis: Active Ankylosing Spondylitis

- ❑ Member is 12 years of age or older
- ❑ Trial and failure of **BOTH** of the preferred drugs below **(check each tried)**:

❑ adalimumab-adbm (Boehringer Ingelheim) **OR** Hadlima® (adalimumab-bwwd)	❑ Enbrel®

❑ Diagnosis: Active Psoriatic Arthritis

- ❑ Member is 2 years of age or older
- ❑ Trial and failure of **TWO (2)** of the preferred drugs below **(check each tried):**

❑ adalimumab-adbm (Boehringer Ingelheim) **OR** Hadlima® (adalimumab-bwwd)	❑ Enbrel®	❑ Pyzchiva® syringe/vial **OR** Starjemza™ (Requires trial and failure of a preferred TNF-alpha inhibitor)

(Continued on next page)

❑ Diagnosis: Moderate to Severe Chronic Plaque Psoriasis

- ❑ Member is 6 years of age or older
- ❑ Member has a diagnosis of moderate to severe plaque psoriasis who is a candidate for systemic or phototherapy
- ❑ Member must have a previous failure on a topical psoriasis agent
- ❑ Trial and failure of **TWO (2)** of the preferred drugs below:

❑ adalimumab-adbm (Boehringer Ingelheim) **OR** Hadlima® (adalimumab-bwwd)	❑ Enbrel®	❑ Pyzchiva® syringe/vial **OR** Starjemza™ (Requires trial and failure of a preferred TNF-alpha inhibitor)

❑ Diagnosis: Non-Radiographic Axial Spondyloarthritis

- ❑ Member is 18 years of age or older
- ❑ Member has a diagnosis of Active Non-radiographic Axial Spondylarthritis (nr-axSpA) with objective signs of inflammation

❑ Diagnosis: Active Enthesitis-related arthritis (ERA)

- ❑ Member is 4 years of age or older
- ❑ Member has a diagnosis of active Enthesitis-Related Arthritis
- ❑ Trial and failure of at least **two (2)** NSAIDs **OR**
- ❑ Use of NSAIDs is contraindicated in patient
- ❑ Trial and failure of **BOTH** of the preferred drugs below:

❑ adalimumab-adbm (Boehringer Ingelheim) **OR** Hadlima® (adalimumab-bwwd)	❑ Enbrel®

❑ Diagnosis: Hidradenitis Suppurativa (HS)

- ❑ Member is at least 12 years old
- ❑ Member has a diagnosis of moderate to severe Hidradenitis Suppurativa
- ❑ Trial and failure of adalimumab-adbm (Boehringer Ingelheim) **OR** Hadlima® (adalimumab-bwwd)

Medication being provided by Specialty Pharmacy - PropriumRx

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.*

***REVISED/UPDATED/REFORMATTED:** ~~10/31/2018; 11/18/2018; 12/30/2018; 4/6/2019; 11/23/2020; 12/21/2020; 7/19/2021; 01/05/22; 1/6/2022; 6/23/2022; 7/7/2022;06/23/2023; 11/8/2023; 6/10/2024; 10/17/2025; 12/12/2025; 1/20/2026, 2/23/2026; 3/6/2026; 6/4/2026.~~ **6/15/2026**